United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: October 5-9, 2015

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with intellectual and developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers the 12 State Supported Living Centers (SSLCs), Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio, and the Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

In 2009, the parties selected three Independent Monitors, each of whom was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that were submitted to the parties. Each Monitor engaged an expert team for the conduct of these reviews.

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures.

Given the intent of the parties to focus upon outcomes experienced by individuals, some aspects of the monitoring process were revised, such that for a group of individuals, the Monitoring Teams' reviews now focus on outcomes first. For this group, if an individual is experiencing positive outcomes (e.g., meeting or making progress on personal goals), a review of the supports provided to the individual will not need to be conducted. If, on the other hand, the individual is not experiencing positive outcomes, a deeper review of the way his or her protections and supports were developed, implemented, and monitored will occur. In order to assist in ensuring positive outcomes are sustainable over time, a human services quality improvement system needs to ensure that solid protections, supports, and services are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

In addition, the parties agreed upon a set of five broad outcomes for individuals to help guide and evaluate services and supports. These are called Domains and are included in this report.

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of

the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

In order to assess the facility's compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities:

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Scoring** – The report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. The parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews. Therefore, none of the figures in this report should be construed as a statement regarding the Facility's compliance with the Settlement Agreement.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
d. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
e. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at El Paso SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The facility director supported the work of the Monitoring Teams, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

Domain #1: The State will make reasonable efforts to ensure that individuals in the Target Population are safe and free from harm through effective incident management, risk management, restraint usage and oversight, and quality improvement systems.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	58% 7/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	71% 5/7	1/1	N/A	1/1	1/1	0/1	0/1	N/A	1/1	N/A

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (December 2014 through August 2015) were reviewed.

The data showed a variable frequency of occurrence in the overall use of crisis intervention restraint over the nine months, from a low of 13 per month to a high of 40 per month. A decrease was not evident, but, if considering only the past five months, the frequency was decreasing. The average duration of a physical crisis intervention restraint showed an increase in the past few months, from less than two minutes through June 2015 to more than five minutes in July 2015 and August 2015.

The frequency of crisis intervention chemical restraints was low for seven of the nine months. Two of the most recent three months, however, had frequencies more than double any other month, which led to the graph line not showing a decrease over the nine-month period. There were no uses of crisis intervention mechanical restraint and no individuals who had protective mechanical restraint for self-injurious behavior. The overall number of individuals who were restrained for crisis intervention remained stable and low over the nine-month period.

The number of restraint-related injuries presented similar to the graph of the frequency of crisis intervention restraints. That is, over the nine-month period, a decrease (or stable low frequency) was not evident, though if only looking at the past five months, a decreasing trend was evident.

The use of chemical and non-chemical restraints for medical and dental procedures was low for the nine-month period.

Thus, state and facility data showed low usage and/or decreases in seven of these 12 facility-wide measures (i.e., crisis intervention mechanical restraint, number of individuals restrained, use of protective mechanical restraint for self-injurious behavior, chemical and

non-chemical restraint for medical and dental).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint (Individual #161, Individual #8, Individual #200, Individual #26, Individual #153 [and one of Individual #13's restraints was also reviewed for a total of six individuals]). Data from state office and from the facility showed decreases in frequency or very low occurrences over the past nine months for four of the six (Individual #161, Individual #8, Individual #200, Individual #13).

The other four individuals did not have any occurrences of crisis intervention restraint or protective mechanical restraint for self-injurious behavior. The Monitoring Team looked to see if any of these individuals had any restraints in the nine-month period preceding the nine-month period reviewed (i.e., March 2014-November 2014). If so, they are then included as an individual who had shown progress in the reduction of restraint occurrences. One of these four individuals (Individual #83) had restraint (one) in that prior nine-month period and, therefore, was included in this indicator.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

			Individuals:								
#	Indicator	Overall Score	#161	#8	#200	#26	#153	#13			
3	There was no evidence of prone restraint used.	100% 11/11	2/2	1/1	2/2	3/3	2/2	1/1			
4	The restraint was a method approved in facility policy.	82% 9/11	2/2	1/1	2/2	1/3	2/2	1/1			
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 11/11	2/2	1/1	2/2	3/3	2/2	1/1			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 8/8	N/A	N/A	2/2	3/3	2/2	1/1			
7	There was no injury to the individual as a result of implementation of the restraint.	100% 11/11	2/2	1/1	2/2	3/3	2/2	1/1			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 11/11	2/2	1/1	2/2	3/3	2/2	1/1			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	17% 1/6	Not rated	Not rated	Not rated	0/3	1/2	0/1			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	82% 9/11	2/2	1/1	2/2	1/3	2/2	1/1			
11	The restraint was not in contradiction to the ISP, PBSP, or medical	0%	0/2	0/1	0/2	0/3	0/2	0/1			

	orders.	0/11									

Comments:
The Monitoring Team chose to review 11 restraint incidents that occurred for six different individuals (Individual #161, Individual #8, Individual #200, Individual #26, Individual #153, Individual #13). Of these, eight were crisis intervention physical restraints, and three were crisis intervention chemical restraints. The crisis intervention restraints were for aggression to staff or peers, self-injury, property destruction, or dangerous unauthorized departure (i.e., walking into oncoming automotive traffic).

4 and 10. Two restraints for Individual #26 (7/26/15, 8/9/15) were labeled as a modified restraint. There was no description in any of the documentation provided of what the modified restraint was and whether it was authorized according to policy.

9. Because criterion for indicator #2 was met for Individual #161, Individual #8, and Individual #200, this indicator was not scored for them. For Individual #26 and Individual #13, assessments were not completed or updated, their PBSPs were not developed or not fully implemented, and they were not engaged in activities or programming.

11. The IRRF section of the ISP did not show a selection of one of the two options in the template to document restraint considerations.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

			Individuals:								
#	Indicator	Overall Score	#161	#8	#200	#26	#153	#13			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

Comments:

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.

			Individuals:								
#	Indicator	Overall Score	#161	#8	#200	#26	#153	#13			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	82% 9/11	2/2	1/1	1/2	2/3	2/2	1/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

13. Nine of the restraints met criterion for this indicator. For Individual #200 5/19/15, the section of the FFA form that records the date/time that restraint monitor arrived (and name) was blank. For Individual #26 7/26/15, all data items in the first three sections FFA were blank (assess the application, assess the consequences, determine if procedures were followed). Even so, the FFA was signed as having been reviewed by the Director of Behavioral Services, the Unit Director, and the IMRT.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.

			Individuals:								
#	Indicator	Overall Score	#161	#8	#200	#26	#153	#13			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	55% 6/11	0/2	1/1	1/2	3/3	1/2	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	100% 4/4	N/A	N/A	1/1	2/2	1/1	N/A			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A			

Comments: a. Although it was positive that for the restraints reviewed, nursing staff initiated monitoring within 30 minutes, and monitored mental status, in five instances, vital signs were not properly monitored. These restraints included those for: Individual #161 on 7/10/15 at 10:20 a.m., and 7/13/15 at 6:09 p.m.; Individual #200 on 3/26/15 at 7:25 p.m.; Individual #153 on 8/19/15 at 3:08 p.m.; and Individual #13 on 8/5/15 at 4:37 p.m. For all restraints, nurses directly observing an individual can take respirations regardless of the individual's cooperation. If an individual refuses to have other vital signs taken this should be documented, as well as later attempts to take a full set of vital signs.

b. It was positive to see that restraint-related injuries or other negative health effects were documented, and when necessary, nursing staff took appropriate actions.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

			Individuals:								
#	Indicator	Overall Score	#161	#8	#200	#26	#153	#13			
15	Restraint was documented in compliance with Appendix A.	100% 11/11	2/2	1/1	2/2	3/3	2/2	1/1			

Comments:
15. The restraints were documented very well.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	#161	#8	#200	#26	#153	#13			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	82% 9/11	2/2	1/1	2/2	1/3	2/2	1/1			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	60% 6/10	2/2	1/1	2/2	1/2	0/2	0/1			

Comments:

16. Nine of the restraints met criterion for this indicator. The restraint for Individual #26 4/2/15 did not include identification of the nurse assessment timeliness issue. The restraint for Individual #26 7/26/15 did not have a thorough review of the restraint. Many of his restraint episodes ended with chemical restraint. The primary actions noted in the ISPA were to purchase underwear and a belt for Individual #26.

17. The restraint for Individual #26 8/9/15 was not included in this indicator because there had not yet been enough time to implement the recommendations when documents were prepared for the Monitoring Team. For Individual #26 7/26/15, Individual #153 4/13/15 and 8/19/15, and Individual #13 8/5/15, no documentation was provided to evidence implementation of recommendations. For Individual #153, this was reported to be due to delays in approval of his crisis intervention plan.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	50% 6/12	0/2	2/2	1/1	1/2	0/3	1/1	1/1		

Comments:

The Monitoring Team reviewed 12 investigations that occurred for seven individuals. Of these 12 investigations, eight were DFPS investigations of abuse-neglect allegations (one confirmed, five unconfirmed, two inconclusive). The other four were for facility investigations of witnessed and discovered serious injuries and an encounter with law enforcement.

- Individual #161, UIR 15-165, DFPS 43559545, confirmed neglect allegation, 2/27/15
- Individual #161, UIR 15-211, discovered serious injury, 2/27/15
- Individual #1, UIR 15-208, DFPS 43750806, inconclusive neglect allegation, 6/3/15
- Individual #1, UIR 15-200, witnessed serious injury, 5/11/15
- Individual #8, UIR 15-225, DFPS 43834637, unconfirmed physical abuse allegation, 7/13/15
- Individual #200, UIR 15-179, DFPS 43595561, inconclusive-unconfirmed physical abuse allegation, 3/30/15

- Individual #200, UIR 15-161, witnessed serious injury, 2/17/15
- Individual #26, UIR 15-144, DFPS 43532766, unconfirmed physical abuse allegation, 2/5/15
- Individual #26, UIR 15-175, DFPS 43577555, unconfirmed physical abuse allegation, 3/14/15
- Individual #26, UIR 15-176, law enforcement encounter, 3/14/15
- Individual #153, UIR 15-195, DFPS 43676072, unconfirmed physical abuse allegation, 5/4/15
- Individual #81, UIR 15-177, DFPS 43586181, unconfirmed physical abuse allegation, 3/23/15

1. For all 12 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes the occurrence of staff criminal background checks and signing of duty to report forms; facility and IDT review of trends; and the development, implementation, and revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

In all cases, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. For eight of the 12 investigations, the facility had looked at any trends of previous occurrences (Individual #161 15-165 and 15-211, Individual #153 15-195, Individual #81 15-177) or there had been no previous occurrences and, therefore, no trend existed (Individual #1 15-208 and -15-200, Individual #8 15-225, Individual #200 15-179). The other four did not analyze trends. Individual #200 15-161 had an injury related to aggression, but his behavioral data most recently analyzed was from 2013, inserted into his 2015 assessment. Similarly, for the three investigations for Individual #26 (15-144, 15-175, 15-176), the most recent data analyzed for trends was from July 2014. Three of the eight investigations, for which a plan was, or should have been, put in place and implemented, had a plan in place and implemented (Individual #200, Individual #153, Individual #81). For Individual #26 UIR 15-176, there was a PBSP in place to address aggression, calling authorities, and property destruction, however, the plan was not fully implemented.

Thus, across the 12 investigations, six met the criteria for this indicator (Individual #1, Individual #8, Individual #153, Individual #81, and one of the two for Individual #200 [15-179]).

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	92% 11/12	1/2	2/2	2/2	1/1	3/3	1/1	1/1		

Comments:

2. The Monitoring Team rated 11 of the investigations as being reported correctly. The other one was rated as being reported late. All were discussed with the facility Incident Management Coordinator while onsite. This discussion along with additional information provided to the Monitoring Team informed the scoring of this indicator. Those not meeting criterion are described below.

- Individual #161 15-211 was an injury that occurred on a Saturday, was determined by the physician to be serious on Monday at 10:15 am, and reported to the facility director at 4:30 pm. The Incident Management Coordinator reported that a recommendation was made and was followed.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 6/6	1/1	Not scored	1/1	1/1	1/1	1/1	1/1		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		

Comments:

3. All staff correctly answered all four of the questions posed by the Monitoring Team.

4. Criterion was met for all of the individuals.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 12/12	2/2	2/2	2/2	1/1	3/3	1/1	1/1		

Comments:

Outcome 5– Staff cooperate with investigations.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
7	Facility staff cooperated with the investigation.	100% 12/12	2/2	2/2	2/2	1/1	3/3	1/1	1/1		

Comments:

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
			Individuals:									
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 12/12	2/2	2/2	2/2	1/1	3/3	1/1	1/1		
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12	2/2	2/2	2/2	1/1	3/3	1/1	1/1		
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	92% 11/12	2/2	1/2	2/2	1/1	3/3	1/1	1/1		
Comments: 8-9. El Paso SSLC investigations were complete and thoroughly documented. 10. All but one of the investigations met criterion for this indicator. The exception was Individual #1 15-208, for which DFPS had an inconclusive finding in response to an allegation of neglect. The incident involved an oxygen concentrator apparently being turned off for a period of time, but there was insufficient and/or conflicting evidence to validate if it was actually turned off (or malfunctioned). The DFPS investigation found that the staff had not been trained in its use, and as a result of IMRT review, the facility decided to develop protocols and train staff. This was good to see. However, because of the potential seriousness of this incident, DFPS should have identified this as a systemic issue and/or found the facility neglectful for not having protocols and staff training in place.											

Outcome 7– Investigations are conducted and reviewed as required.												
			Individuals:									
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
11	Commenced within 24 hours of being reported.	100% 12/12	2/2	2/2	2/2	1/1	3/3	1/1	1/1		
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 12/12	2/2	2/2	2/2	1/1	3/3	1/1	1/1		
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the	92% 11/12	1/2	2/2	2/2	1/1	3/3	1/1	1/1		

	investigation was thorough and complete and (2) the report was accurate, complete, and coherent.										

Comments:
11-12. All investigations met the timeline requirements.

13. For facility-only investigations, El Paso SSLC did not use the standard review/approval form. Instead, the UIR review/approval signature was used, which is acceptable, but in one case (Individual #161 15-211), the late reporting was not identified in the UIR and, thus, the supervisory review was inadequate.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		

Comments:

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81		
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 7/7	2/2	2/2	N/A	N/A	3/3	N/A	N/A		
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 2/2	1/1	1/1	N/A	N/A	N/A	N/A	N/A		
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	86% 6/7	1/2	2/2	N/A	N/A	3/3	N/A	N/A		

Comments:
Seven investigations had recommendations and, therefore, were used for scoring these indicators (the investigations for Individual #161, Individual #1, and Individual #26).

18. The recommendations for Individual #161 15-211 for sleep study and a walking program were not implemented.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes										
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No										
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No										
Comments:												

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen for review are monitored with these indicators.)												
			Individuals:									
#	Indicator	Overall Score	#161	#8								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	33% 1/3	1/2	0/1								
48	Multiple medications were not used during chemical restraint.	100% 3/3	2/2	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	67% 2/3	2/2	0/1								
Comments:												

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/4	0/1		0/1	0/1			0/1		
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. The State did not have a policy for determining whether or not individuals met criteria for the use of TIVA. The policy the Facility developed did not address the important issue of medical perioperative evaluation (i.e., it does not require one). The standard of care requires that individuals that meet certain criteria (e.g., age, medical problems, etc.) undergo a perioperative evaluation by the primary care practitioner. Individuals at El Paso for whom general anesthesia is used should be subjected to the same standard, but they are not. b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.										

Outcome 9 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: a. Based on the individual records the Facility submitted, none of the individuals in the group the Monitoring Team responsible for physical health reviewed had pre-treatment sedation for medical appointments in the previous six months.											

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
			Individuals:								
#	Indicator	Overall Score									
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	N/A									

2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	N/A										
3	Action plans were implemented.	N/A										
4	If implemented, progress was monitored.	N/A										
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A										
Comments: 1-5. None of the individuals reviewed were reported to have received PTS (at the facility) for routine medical or dental care for the time period reviewed by the Monitoring Team.												

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.												
			Individuals:									
#	Indicator	Overall Score	#50									
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 1/1	1/1									
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/1	0/1									
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/1	0/1									
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/1	0/1									
e.	Recommendations are followed through to closure.	0% 0/1	0/1									
Comments: a. Since the last review, one individual died. Individual #50's causes of death were listed as Pulmonary embolism, sepsis, and acute bronchopneumonia. Timely death reviews were completed for Individual #50. b. through d. Some of the concerns with regard to recommendation included:												

- Recommendations did not appear to sufficiently address the magnitude of the continuity of care issues associated with the death. For example, nursing assessments were not addressed, including their frequency in the evaluation and re-evaluation of risk associated with the health condition (e.g., related to C-Diff infection requiring isolation).
- Recommendations for training and education were vague. They were not stated in measurable terms to allow a determination of whether improvement occurred, or to define which specific discipline members were to be trained.

e. The Administrative Death Review Report listed seven items under the header Committee Recommendations. From the documentation provided in the document request, it could not be discerned that the list of recommendations were fully implemented.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	ADRs are reported immediately.	100% 1/1						1/1			
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1						1/1			
c.	Clinical follow-up action is taken, as necessary, with the individual.	100% 1/1						1/1			
d.	Reportable ADRs are sent to MedWatch.	N/A						N/A			
Comments: a. Individual #5 had a cough related to Lisinopril. The medication discontinued and the cough "subsided."											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 2/2
Comments: a. and b. El Paso SSLC completed two DUEs, including the use of antibiotics in January 2015, and Vitamin D supplementation in May 2015. The January 2015 DUE generated a series of clinically relevant recommendations related to the use of antibiotics at the Facility. One recommendation was to develop an antibiotics stewardship committee. The May 2015 minutes listed that as an ongoing project.		

Domain #2: Using its policies, training, and quality assurance systems to establish and maintain compliance, the State will provide individuals in the Target Population with service plans that are developed through an integrated individual support planning process that address the individual's strengths, preferences, choice of services, goals, and needs for protections, services, and supports.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#153	#81	#13	#119			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:

The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #161, Individual #1, Individual #153, Individual #81, Individual #13, and Individual #119. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the El Paso SSLC campus.

1. None of the individuals had a full array of individualized personal goals. Most goals were very broadly stated, contained generic outcomes, and were identical for many individuals. For example, the living option goal for four of the six individuals stated will live in the most integrated setting consistent with his/her preferences, strengths, and needs. Goals did not identify preferences for specific day activity or living options and, in many instances, did not offer an opportunity to learn new skills. For example, Individual #153's employment goal stated, will attend the workshop. The outcome did not identify job preferences or work skills needed to maintain a preferred job.

2. Goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting goals had been achieved. Examples of personal goals that were not measureable included Individual #153's goal to complete ADLs with less assistance, Individual #161's goal to be independent when choosing her leisure activities, and Individual #119's goal to make more independent choices.

3. Reliable and valid data to determine progress on goals were not available for most action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. In some cases, it was noted that goals were never

fully implemented during the ISP year.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#153	#81	#13	#119			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: In order to develop action plans to address personal goals, IDTs will have to define what the individual would like to achieve and then develop action steps to support the individual to achieve his or her personal goals. Once El Paso SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.											

8. Personal goals were not well defined in the ISPs and it was often difficult to determine what skills the individual would need to learn to achieve goals. Many of the action plans were written for training on skills that the individual had already mastered. For example, Individual #81 had an action plan for shredding paper at the workshop. His ISP indicated that he could already do this task. For two individuals (Individual #13 and Individual #119), the IDT developed outcomes that were not carried over to the action plan pages, thus, action plans were not developed for some outcomes. Individual #13 did not have action plans developed for his personal goals related to relationships or leisure.

9. Individuals had limited opportunities to learn new skills based on identified preferences. In most cases, there was no discussion regarding preferences for day programming. ISPs did not include discussion regarding opportunities for choice throughout the day. Supporting individuals to make choices and express preferences would be a first step in the IDT determining individual preferences for living options and day programming.

10-11. Without well-defined personal goals, it was difficult to determine if action plans would support the individuals to be more independent. Action plans to support independence were often not measurable, thus, it was unlikely that consistent implementation would occur.

12. All individuals had an IHCP to address risks, however, supports to address risk were not typically integrated into other parts of the ISP. It was particularly concerning that there was little evidence that data were consistently gathered to identify risks or a change in status. In some cases, risk were identified through the IMRT process, but it was difficult to determine if addressed by the IDT due to a lack of documentation.

13. ISPs did not integrate all support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs. While there was usually a description of communication, OT, PT, and psychiatric supports in the ISP, ancillary plans were not integrated into the goals and action plans in a meaningful way. Recommendations and strategies were generally not used to develop teaching and support strategies for SAPS and service objectives. For example, Individual #1's therapy supports were not used to develop her SAPS; Individual #81 N's recommendations for behavioral supports in his behavioral health assessment were not used to develop his action plans for attending the dentist or for community outings (though data indicated that he often refused both), and Individual #13's SAPs included general communication strategies, though not specific to the skill being taught.

14. Overall, there was a lack of focus on specific plans for community participation that would have promoted any meaningful engagement or integration. Only one individual (Individual #1) had action plans that might support integration in the community through participation in a community senior citizen program and church. Individual #119 and Individual #13 had no action plans to be implemented in the community. Individual #161, Individual #153, and Individual #81 had action plans to support outings in the community, however, action plans did not support community integration.

15. Action plans to support work and day programming did not address skills that were required for jobs or activities based on the individual's preferences. There was little consideration of what the individual wanted to learn or do during the day. Individual #1 and

Individual #81's IDTs requested further assessments to try to determine work preferences and interests. Those assessments were not completed. Individuals did not have opportunities to explore employment options or learn work skills that might transfer into a more integrated setting. Individual #119's IDT did not develop any goals for day programming or describe how she would spend her day.

16. ISP action plans did not offer opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet identified needs. Most individuals were not observed to be functionally engaged during the majority of Monitoring Team observations.

17. None of the ISPs addressed barriers to achieving goals. Documentation indicated that action plans and supports were not regularly implemented or monitored for any of the individuals. IDTs did not meet to discuss barriers to implementation.

18. Action steps were not written with enough detail to ensure consistent implementation, data collection and review. For example,
- Individual #153's action plans to support his vocational, living option, and recreation goals did not include information on the frequency of implementation.
- The frequency of implementation column was left blank for Individual #81's action plans to support his relationship and recreation goals.
- Action plans were never developed for Individual #13's recreation, relationship, and living option goals.
- Individual #119 did not have any measurable action steps with enough information to ensure consistent implementation.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#153	#81	#13	#119			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	50% 3/6	1/1	1/1	0/1	0/1	0/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the	80% 4/5	1/1	1/1	1/1	0/1	1/1	N/A			

	community).										
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	0% 0/5	0/1	0/1	0/1	0/1	0/1	N/A			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1			

Comments:

19. Two of six ISPs (Individual #13, Individual #119) included a description of the individual's preference and how that was determined. Individual #161 was asked where she wanted to live, however, she was unable to provide a response. The IDT did not describe how it otherwise determined what her preference might be.

20. Individual #1's ISP meeting was observed by the Monitoring Team. The IDT stated that her living preferences were unknown. There was no further discussion regarding what she might prefer in regards to her living options.

21. Three of the six ISPs included recommendations from all relevant supports staff.

22. Six of the ISPs met criterion for this indicator.

23. Four of the ISPs did not document discussion regarding the individual's preference for living options

24. Four ISPs met criterion. Individual #81's ISP noted that behavior was an obstacle, but the IDT did not identify what behavior might be an obstacle or what particular supports may not be available in the community.

26. None of the ISPs included measurable action plans to address barriers to referral (five individuals) or to address barriers to transition if referred (one individual). When the IDT determines that problem behavior is an obstacle to placement, team members should then identify, in measurable terms, what needs to happen for a referral to be considered. Examples include the amount of time with no exhibition of problem behavior, various indicators of behavioral/psychiatric stability, identification of supports and providers in the community, what supports are needed that are not available in the community, etc.

28. ISPs did not include action plans to educate individuals or LARs about community living options. It was clear that the team offered general information to all individuals and LARs on an annual basis. Information, however, did not include specific information on how the individual's preferences and needs might be supported in other living environments. IDTs should consider focusing on

individualized options that are available and could support each individual's needs.

29. For the one individual referred for transition to the community (Individual #119), the IDT developed an action plan to meet again to discuss referral. There was no documentation that this meeting ever occurred or that additional action steps were developed to address transition.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#153	#81	#13	#119			
30	The ISP was revised at least annually.	100% 5/5	1/1	1/1	N/A	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

30-31. ISPs were revised every year and within 30 days for new admissions.

32. ISPs were not fully implemented for any of the individuals.

- Individual #161's QIDP July 2015 monthly review indicated that her SAPs for leisure and greater independence were not implemented until July 2015, three months after her ISP was developed.
- Individual #1's SAP data and QIDP monthly reviews indicated that her ISP was not fully implemented within 30 days. Her March 2015 monthly review documented that her action plan to be assessed for use of a switch by November 2014 had not been implemented.
- Individual #153's June 2015 QIDP monthly review indicated that data were not available for four out of six action plans.
- Individual #81's QIDP monthly reviews only included documentation of implementation for one of his SAPs.
- Individual #13's IDT never developed action plans for his recreation, leisure, or living option goals.
- Individual #119's IDT never developed action plans for her relationship and day programming goals.

33. Two individuals attended the annual ISP development meeting, as evidenced by the ISP signature sheet.

34. Some important IDT members were not in attendance at the annual IDT meeting for six of the six individuals. Without input from those key team members, it was unlikely that supports were comprehensive to meet all needs.

- Individual #161's PCP and psychiatrist did not attend her annual meeting. Given her complex medical and psychiatric needs, the IDT needed their input to develop appropriate supports.
- Individual #1's PCP and day habilitation staff did not attend her meeting.
- DSPs were not present for Individual #153 's meeting. He was a new admission to the facility, so input from DSPs who knew him best would have benefited the team in planning supports.
- Individual #81's behavioral support staff, OT, PT, PCP, and vocational staff did not attend his ISP development meeting.
- Individual #13's DSP and home manager were not present at his meeting.
- Individual #119's behavioral support staff, SLP, PCP, psychiatrist, and day habilitation staff were not present at her meeting.

Outcome 6: ISP assessments are completed as per the individuals' needs.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#153	#81	#13	#119			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

Comments:
Monitoring of the timeliness, content, and quality of the various assessments for the individual's ISP are reported in those clinical services sections of this report.

35. Five individuals had an ISP Prep meeting where the IDT should have identified assessments recommended by the IDT prior to the annual ISP meeting. ISP Prep documentation did not identify which assessments were recommended for four individuals. Individual #153 was recently admitted to the facility, thus, did not have an ISP Prep meeting.

36. All relevant assessment to assist the team in planning were obtained for Individual #119, but not for the other five individuals.

- Individual #161's FSA, physical, and vocational assessment were not submitted 10 days prior to her annual ISP meeting.
- Individual #1's PSI was not submitted 10 days prior to her meeting.
- Individual #153's FSA, physical, dental, psychiatric assessment, and vocational assessment were all submitted late.
- Individual #81's psychiatric assessment was based on data over one year old and his PSI was submitted late.
- Individual #13's physical and recreational assessment were submitted less than 10 days prior to his annual ISP meeting.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#153	#81	#13	#119			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37-38. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent reliable data were not available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members always reviewed supports and took action as needed when individuals failed to make progress on outcomes or experienced regression.

When IDTs did identify regression, recommendations were often not implemented. For example,

- Individual #161's team recommended a sleep study due to regression on 6/25/15. It had still not been completed at the time of the Monitoring Team's visit. On 7/25/15, her team requested a revision to her PBSP. Minutes from the IMRT meeting on 10/5/15 showed that this was not yet done.
- A HOBE assessment was requested by the IDT for Individual #1 due to GI issues. It has not been completed. The IDT also requested a communication assessment to assess for the use of a switch. There was no evidence that the assessment was completed.
- Individual #81's IDT recommended an updated vocational assessment at his annual ISP meeting. An ISPA dated 6/5/15 indicated that he was still waiting on an updated vocational assessment. Another ISPA on 7/17/15 noted that the assessment had still not been completed.
- An ISPA for Individual #13 dated 5/13/15 indicated that his behavioral health specialist would develop money and calendar SAPs to address behavioral regression. The SAPs had not been developed at the time of the Monitoring Team's visit.

QIDPs were not reviewing services and supports monthly. The Monitoring Team requested QIDP monthly reviews for the past six months for each individual. For all individuals, monthly reviews from March 2015 through August 2015 were dated September 2015. One individual had a note in her record stating that the monthly review would be completed by the time the Monitoring Team visited.

Outcome 1 – Individuals at-risk conditions are properly identified.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The IDT uses supporting clinical data when determining risks levels.	61% 11/18	1/2	1/2	2/2	2/2	0/2	1/2	1/2	1/2	2/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	44% 8/18	1/2	1/2	2/2	2/2	0/2	1/2	0/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #90 – UTIs, and fluid imbalance; Individual #123 – skin integrity, and UTIs; Individual #13 – constipation/bowel obstruction, and seizures; Individual #119 – gastrointestinal problems, and constipation/bowel obstruction; Individual #161 – gastrointestinal problems, and constipation/bowel obstruction; Individual #5 – gastrointestinal problems, and constipation/bowel obstruction; Individual #59 – UTIs, and infections; Individual #24 – constipation/bowel obstruction, and gastrointestinal problems; and Individual #1 – skin integrity, and respiratory compromise).

a.i through a.iii. The IDTs that effectively used supporting clinical data when determining a risk level were those for Individual #90 – UTIs; Individual #123 – UTIs; Individual #13 – constipation/bowel obstruction, and seizures; Individual #119 – gastrointestinal problems, and constipation/bowel obstruction; Individual #5 – gastrointestinal problems; Individual #59 – UTIs; Individual #24 – gastrointestinal problems; and Individual #1 – skin integrity, and respiratory compromise.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
4	The individual has goals/objectives related to psychiatric status.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-6. Psychiatry related goals for individuals were related to the reduction of problematic behaviors, such as aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. This will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

7. Although El Paso SSLC had not developed measurable goals that met the criterion in the above indicators, behavioral data were being collected, such as frequency counts of overt behaviors, such as aggression or self-injury that allow a reviewer to make an assessment of the individual's status regarding these overt problematic behaviors, but not regarding the actual status of his or her psychiatric condition.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/2	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	75% 6/8	1/1	N/A	0/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:
12-14. All individuals had a CPE, formatted as per Appendix B, and with comprehensive content. The exception was that Individual #153's CPE was missing two components: physical examination and treatment recommendations. Six individuals had evaluations in 2011 or 2012. The remainder were performed more recently, with the most recent in May 2015. The evaluators did a good job of reviewing the psychiatric history and other historical information.

15. For individuals admitted since 1/1/14, the initial psychiatric evaluation was performed within 30 days, however, there was no documentation of an initial progress note reflecting the face-to-face assessment at the time of admission.

16. There were issues with the use of outdated diagnoses in the records of Individual #8 and Individual #83. For example, diagnoses were not consistent when comparing the psychiatric documents and medical assessments.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
17	Status and treatment document was updated within past 12 months.	100% 7/7	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/7	0/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	50% 4/8	1/1	N/A	1/1	0/1	1/1	0/1	0/1	0/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	38% 3/8	0/1	N/A	0/1	0/1	0/1	1/1	1/1	1/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	13% 1/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments:

17. Individual #153 had not been residing in the facility long enough to require an updated evaluation.

18. The Monitoring Team scores 16 aspects of the annual document. Overall, from four to 10 aspects were missing from each evaluation. Five of the annual evaluations were performed by an interim provider. Many of these evaluations were incomplete, with much of the document left blank in spite of it containing prompts to include information. Where information was included, it was brief and insufficient.

20. In five examples, there was no signature indicating psychiatric participation in the individual's ISP meeting. Of the three examples where psychiatry attended, one of these was attended by a Psychiatric LVN.

21. For those meetings where the psychiatrist was present, there was evidence of the psychiatrist's participation in the ISP meeting. There was a need for improvement with regard to the documentation of this discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of

the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation. There was an overall need for improvement with regard to the ISP with specific focus on the integration of psychiatry with other clinical disciplines.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1

Comments:
22. Individual #60 and Individual #83 had a PSP in place. A PBSP was being developed for Individual #83.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	50% 4/8	0/1	N/A	1/1	0/1	1/1	1/1	0/1	0/1	1/1
29	The written information provided to individual and to the guardian was adequate and understandable.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	13% 1/8	0/1	N/A	0/1	0/1	1/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	25% 2/8	0/1	N/A	0/1	0/1	1/1	1/1	0/1	0/1	0/1

Comments:
28. Consents were completed for four of the individuals. There were medications where consents were not available (e.g., Trazadone). Per discussions with the facility psychiatrist, the psychiatrists were not completing informed documentation for this medication. Any medication prescribed by psychiatry should have documentation of the informed consent process.

30-31. There was a brief review of risks versus benefit in the consent documentation, with more detailed information included in the annual assessment or quarterly psychiatric reviews. Similar issues were noted with alternate and non-pharmacological interventions that were considered. In the case of Individual #26, new consent forms recently approved by state office were utilized, resulting in

improvements in documentation.

32. HRC documentation was only available for Individual #153 and Individual #26. HRC review is required prior to the initiation of medication and annually.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.										
			Individuals:							
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	88% 7/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	0/1	N/A
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	83% 5/6	0/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A
3	The psychological/behavioral goals/objectives are measurable.	83% 5/6	0/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A
4	The goals/objectives were based upon the individual's assessments.	33% 2/6	0/1	N/A	0/1	0/1	1/1	0/1	1/1	N/A	N/A
5	Reliable and valid data are available that report/summarize the individual's status and progress.	83% 5/6	0/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A

Comments:

1. Of the 16 individuals reviewed by both Monitoring Teams, eight required a PBSP (seven of the individuals reviewed by the behavioral health Monitoring Team and one individual reviewed by the physical health Monitoring Team). All had a PBSP, except for one individual (Individual #83). The behavioral health services department, however, had developed a functional assessment and PBSP for Individual #83 that was awaiting final approval.

2. Of the six individuals' PBSPs, only Individual #161's PBSP did not have treatment goals/objectives.

4. The treatment goals/objectives in the PBSP were consistent with the information found in the functional assessments for two of the individuals (Individual #26, Individual #81). Individual #8's functional assessment and PBSP had inconsistent target behaviors. Individual #200's functional assessment and PBSP identified different functions of the target behaviors. Individual #153's assessment data indicated a higher level of target behaviors than found in his objectives.

5. It was encouraging to see that all six of the individuals with PBSP data had monthly interobserver agreement (IOA) and data timeliness data suggesting that treatment data were reliable. The validity of Individual #161's PBSP data, however, was questioned by the behavioral health services staff and were rated as not reliable and valid.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
10	The individual has a current, and complete annual behavioral health update.	67% 6/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	50% 3/6	0/1	N/A	0/1	1/1	1/1	1/1	0/1	N/A	N/A
12	The functional assessment is complete.	83% 5/6	1/1	N/A	0/1	1/1	1/1	1/1	1/1	N/A	N/A

Comments:

10. All nine individuals reviewed had annual behavioral health assessments that were complete and revised within the last 12 months. Three (Individual #8, Individual #200, Individual #26), however, contained behavioral and/or psychiatric data that were more than 12 months old and, therefore, were judged as not being current.

11. Three of the six functional assessments reviewed were current (Individual #153, Individual #26, Individual #200). Individual #81's functional assessment was dated in the last 12 months, however the direct assessment was dated as having occurred three years ago. Direct and indirect assessments should be conducted annually. Individual #161 and Individual #8's functional assessments were dated 4/28/14 and 7/14/14, respectively.

12. The majority of the functional assessments reviewed were complete and contained all of the required components. One functional assessment (Individual #8), however, did not contain clear summary statements.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	33% 2/6	0/1	N/A	1/1	0/1	1/1	0/1	0/1	N/A	N/A
14	The PBSP was current (within the past 12 months).	50% 3/6	0/1	N/A	0/1	0/1	1/1	1/1	1/1	N/A	N/A
15	The PBSP was complete, meeting all requirements for content and	50%	0/1	N/A	0/1	0/1	1/1	1/1	1/1	N/A	N/A

	quality.	3/6									

Comments:
13. Individual #8 and Individual #26's PBSPs were implemented within 14 days after attaining the necessary consents.

14. Individual #161 (dated 4/21/14), Individual #8 (dated 2/23/14), and Individual #200's (dated 3/13/14) PBSPs were not revised in the last 12 months.

15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Three of the six PBSPs (Individual #26, Individual #153, Individual #81's) were scored as complete. Three PBSPs were rated as incomplete because they did not include treatment objectives (Individual #161), or treatments based on the results of the functional assessment (Individual #8, Individual #200).

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A

Comments:
24-25. Individual #26 and Individual #153 were receiving counseling/psychotherapy at the time of the onsite review. Treatment plans and progress notes were complete for both of them.

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual receives quality quarterly medical reviews.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: b. and c. For the individuals reviewed, it was positive that the AMAs were completed timely. However, quarterly assessments were not completed timely.

d. As applicable to the individuals reviewed, aspects of the annual medical assessments that were consistently good included social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, updated active problem lists, and plans of care for each active medical problem, when appropriate. Problems varied across assessments, but areas that were problematic included pre-natal histories, family history, and childhood illnesses.

e. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	72% 13/18	1/2	2/2	1/2	2/2	2/2	2/2	1/2	1/2	1/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #90 – aspiration, and osteoporosis; Individual #123 – diabetes, and cardiac disease; Individual #13 – seizures, and diabetes; Individual #119 – gastrointestinal problems, and osteoporosis; Individual #161 – seizures, and circulatory; Individual #5 – diabetes, and osteoporosis; Individual #59 – other: hypertension, and seizures; Individual #24 – seizures, and osteoporosis; and Individual #1 – cardiac disease, and respiratory compromise).

The five ISPs/IHCPs that did not sufficiently identify the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #90 – aspiration, Individual #13 – diabetes, Individual #59 – other: hypertension, Individual #24 – osteoporosis; and Individual #1 – respiratory compromise.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. It was positive that for the individuals reviewed, dental examinations were completed within 365 of the previous one, but no earlier than 90 days, and dental summaries were completed no later than 10 working days prior to the ISP meeting.

b. The dental exam for Individual #123, who was edentulous, contained all of the necessary components. For the remaining individuals reviewed, dental exams included the following:

- A description of the individual's cooperation;
- Information about oral cancer screening;
- A description of periodontal condition;
- An odontogram;
- A description of treatment provided;
- The recall frequency; and
- Treatment plans.

However, dental exams were missing one or more of the following:

- An oral hygiene rating completed prior to treatment;
- Information about the individual's last x-rays and the type of x-rays;

- Periodontal charting.
- The number of teeth present/missing;
- Caries risk; and
- Periodontal risk.

c. All of the dental summaries were missing one or more of the required elements. The following elements were included in all of the dental summaries reviewed:

- Recommendations related to the need for desensitization or other plan;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations; and
- Treatment plan, including the recall frequency.

Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable:

- The number of teeth present/missing;
- Effectiveness of pre-treatment sedation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of oral hygiene instructions to staff and the individual; and
- A description of the treatment provided.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	67% 6/9	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0/18									
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	27% 3/11	1/1	0/1	N/A	N/A	0/2	0/2	1/2	0/1	1/2

Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #90 – UTIs, and fluid imbalance; Individual #123 – skin integrity, and UTIs; Individual #13 – constipation/bowel obstruction, and seizures; Individual #119 – gastrointestinal problems, and constipation/bowel obstruction; Individual #161 – gastrointestinal problems, and constipation/bowel obstruction; Individual #5 – gastrointestinal problems, and constipation/bowel obstruction; Individual #59 – UTIs, and infections; Individual #24 – constipation/bowel obstruction, and gastrointestinal problems; and Individual #1 – skin integrity, and respiratory compromise). For the risks reviewed, the annual comprehensive nursing assessments did not contain reviews of them that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. Nursing assessments were completed in accordance with nursing protocols or current standards of practice for changes of status related to the following: Individual #90 – fluid imbalance, Individual #59 – UTIs, and Individual #1 – respiratory compromise.

An overall concern related to nursing assessments was the lack of assessments consistent with nursing protocols for injuries/skin issues/skin integrity. Throughout the majority of the records reviewed in which injuries were documented, or abrasions, tears, etc. were reported, nursing follow-up for these problems was not consistently documented. For example, skin injuries were not measured and when the individual required treatment with prescribed medication, nursing standards of care for documenting assessment of the individual's response to the treatment regimen often were not followed. The Facility's nursing staff should track all discovered injuries/skin issues to resolution.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2

b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	11% 2/18	0/2	0/2	1/2	1/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	11% 2/18	0/2	0/2	1/2	0/2	0/2	1/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.										
			Individuals:							
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0/4	0/1	0/1	N/A	N/A	0/1	N/A	N/A	N/A	0/1

b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	100% 2/2	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	33% 1/3	0/1	1/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	25% 1/4	0/1	1/1	N/A	N/A	0/1	N/A	N/A	N/A	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	75% 3/4	1/1	0/1	N/A	N/A	1/1	N/A	N/A	N/A	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	33% 1/3	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	50% 1/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	1/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1

Comments: a. through d., and f. For the four individuals that should have been referred to the PNMT:

- Documentation for Individual #90 was not sufficient to determine if the IDT made a timely referral. Apparently, on 4/7/15, pneumonia that occurred in January 2015 was "reclassified as aspiration pneumonia," and as such the IDT then made referral to the PNMT. Per meeting minutes, the IDT had also referred him to the PNMT on 1/21/15. The qualifying event for re-referral at that time was hospitalization for respiratory illness. PNMT meeting minutes indicated that referral was 1/26/15 due to pneumonia and unplanned weight loss. Per documentation, the IDT requested that the PNMT assist them in monitoring him. Subsequently, he experienced another respiratory event in April 2015, resulting in another referral (though the PNMT appeared to be monitoring him since January 2015). At this time, a comprehensive assessment was conducted, and completed on 5/6/15. It is not clear why an assessment was not conducted in January/February at the time of weight loss and respiratory illness. Per previously established discharge criteria, he should have received a comprehensive assessment at that time. The comprehensive evaluation identified repeated aspiration pneumonias on 3/2/13, 5/17/13, 6/17/14, 1/20/15, and a subsequent aspiration pneumonia occurred on 5/14/15.
- For Individual #123, there was a significant delay in the identification of aspiration pneumonia, which resulted in a delay in PNMT action. She was referred on 8/26/15, for aspiration pneumonia on 8/4/15. On 8/26/15, a meeting was held to discuss

her concerns with a due date for the assessment set for 9/30/15, which was after document request deadline.

- On 7/31/15, Individual #161 was referred to the PNMT related to aspiration and weight loss. She had lost 19.5 pounds over the last six months, though initially the weight loss was planned due to obesity. It was determined, however, that further weight loss was not indicated. It was unclear, though, why the IDT did not refer her to the PNMT sooner related to weight loss. In December 2014, she lost 13 pounds, and then in May, she lost nine pounds, and there was some indication that the weight loss might have been related to issues other than planned weight loss. She had a hospitalization that met criteria for referral related to aspiration, and for this issue, the IDT referred her in a timely manner. The PNMT reviewed the referral and determined that a comprehensive assessment was indicated and it was initiated on 8/5/15. The due date for this assessment was identified as 9/2/15, but was identified as not available at the time of the document request.
- For Individual #1, there was evidence of pneumonia in November 2014, respiratory distress/failure hospitalization in June 2015, and pneumonia again in August 2015. The IDT did not refer her to the PNMT, but the PNMT met with IDT and implemented recommendations. They stated that they would wait until a diagnosis of aspiration pneumonia was established before making a referral and conducting an evaluation.

e. For Individual #123, the RN Hospitalization Review and PNMT review of it did not address whether any changes to PNMP were required related to her hospitalization in March 2015.

g. For Individual #1, evidence of a thorough PNMT review was found in the PNMT post-hospitalization assessment note, PNMT meeting minutes, and an ISPA. For Individual #161, per the 7/20/15 ISPA, the PNMT should have conducted at least a review of her weight loss in June to July, but did not.

h. As discussed above, individuals that should have had PNMT comprehensive assessments, and/or did not have timely assessments.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	28% 5/18	0/2	0/2	0/2	1/2	0/2	0/2	2/2	2/2	0/2

b.	The individual's plan includes preventative interventions to minimize the condition of risk.	39% 7/18	0/2	1/2	0/2	1/2	0/2	1/2	2/2	1/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	28% 5/18	0/2	0/2	0/2	1/2	0/2	1/2	2/2	1/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	39% 7/18	0/2	2/2	0/2	1/2	0/2	0/2	2/2	2/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT were responsible for developing. These included IHCPs related to: aspiration, and weight for Individual #90; aspiration, and falls for Individual #123; choking, and falls for Individual #13; choking, and fractures for Individual #119; aspiration, and weight for Individual #161; choking, and falls for Individual #5; falls, and fractures for Individual #59; aspiration, and falls for Individual #24; and aspiration, and skin integrity for Individual #1.

a. ISPs/IHCPs reviewed generally did not sufficiently address individuals' PNM needs, and often did not include preventative measures to minimize the individual's condition of risk. Overall, many action steps, including strategies and interventions were missing, and the etiology of the issue often was not addressed. On a positive note, the IHCPs that addressed PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP) were those for: choking for Individual #119; falls, and fractures for Individual #59; aspiration, and falls for Individual #24.

b. The IHCPs that included preventative interventions to minimize the condition of risk were those for falls for Individual #123; choking for Individual #119; falls for Individual #5; falls, and fractures for Individual #59; falls for Individual #24; and aspiration for Individual #1.

c. All individuals reviewed had PNMPs. All of the PNMPs included some, but not all of the necessary components to meet the individuals' needs. Common problems in most of the PNMPs were that risk levels related to supports and individual triggers were not identified, and medication administration instructions were not complete.

d. None of the IHCPs identified the actions steps necessary to meet the identified objectives.

e. None of the IHCPs reviewed identified the necessary clinical indicators.

f. IHCPs reviewed that defined individualized triggers, and actions to take when they occur were those for choking for Individual #119; falls for Individual #5; falls, and fractures for Individual #24; and falls for Individual #24.

g. The IHCPs that defined the frequency of monitoring were those for aspiration, and falls for Individual #123; choking for Individual #119; falls, and fractures for Individual #59; and aspiration, and falls for Individual #24.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	33% 1/3	1/1				0/1				0/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1	N/A				0/1				N/A

Comments: Individual #161 ate orally at time of IRRF, dated 4/9/15. The IRRF stated that a tube was necessary, because her medical status would "go down" without it. There was an implication that her behavior changes, and the IDT uses the tube as a backup, but the rationale was inadequately documented. The IRRF provided no specific data to substantiate the need for the tube. Data including, but not limited to the following would be necessary to justify the team's decision: number of medication refusals, number of meals at which her behavior was determined to be unsafe, number of times enteral nutrition was used as a substitute for oral intake, etc. Individual #1's ISP and IRRF did not provide justification beyond saying she was at continued high risk for aspiration.

As noted in the Monitoring Team's audit tool, in order to determine medical necessity of enteral nutrition, documentation should include the following:

- Nutritional assessment of current type of formula and schedule;
- Identification of primary medical diagnosis that contributes to the need for non-oral means of nutrition; and
- Assessment of oral motor status by SLP and/or OT to provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	44% 4/9	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1

b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	44% 4/9	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	33% 3/9	1/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1

Comments: a. and b. Based on the signatures on the assessment, Individual #90's OT/PT assessment was not completed 10 days prior to his ISP meeting. In other instances, assessments should have been completed after individuals experienced OT/PT-related changes in status, including but not limited to hospitalizations, but were not.

e. It was positive that three of comprehensive OT/PT Assessments of Current Status/Evaluation Update included all of the necessary components. Problems varied across the remaining assessments and updates. However, the remaining assessments were missing one or more of the following elements:

- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	33% 1/3	N/A	N/A	0/1	N/A	0/1	N/A	N/A	1/1	N/A

Comments: a. Individual #119's ISP provided a clinical description of her OT/PT status (i.e., as opposed to a functional description). Most statements related to "no change" in skills rather than describing her skills and abilities.

b. For most of the individuals reviewed, based on documentation in the ISP, it was unclear whether or not IDTs reviewed and approved necessary changes to individuals' PNMPs.

d. OT/PT services initiated outside of an ISP meeting that the IDT discussed and approved in an ISPA meeting included replacement of Individual #24's orthotic shoes.

Those for which ISPA meetings were not held were for Individual #161's OT/PT services (i.e., as listed in the Facility's list of individual's receiving direct therapy), and Individual #13's physician-ordered therapy post surgical repair of the quadriceps tendon.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1

a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	78% 7/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: e. Problems varied across updates, but in all updates reviewed, most of the key components were not sufficient to address the individual's strengths, needs, and preferences. The only component that was adequate in eight of the nine updates reviewed was the discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and											

services. Based on the problems identified in the updates reviewed, moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	56% 5/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	13% 1/8	0/1	0/1	N/A	1/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments: Generally, individuals' ISPs did not include communication supports to meet their needs. As discussed above, one problem was that communication assessments did not effectively identify needed supports, and this was evident in the ISPs. This might be due

to the fact that communication assessments were combined with OT/PT assessments, and lacked much of the information necessary for a thorough communication evaluation. Another problem was that some meaningful SAPs that were recommended in communication assessments were not included in individuals' ISPs, and IDTs had not provided sufficient justification for not including them.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	70% 16/23	2/2	2/2	1/3	3/3	1/3	2/3	0/1	2/3	3/3
3	The individual's SAPs were based on assessment results.	65% 15/23	2/2	1/2	3/3	2/3	1/3	1/3	1/1	1/3	3/3
4	SAPs are practical, functional, and meaningful.	39% 9/23	1/2	0/2	2/3	1/3	0/3	1/3	0/1	1/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	13% 3/23	0/2	1/2	0/3	0/3	0/3	1/3	0/1	1/3	0/3

Comments:

1. All nine individuals reviewed had skill acquisition plans (SAPs).

2. The Monitoring Team chooses three current SAPs for each individual for review. Only two SAPs with data were available for review for Individual #161 and Individual #1, and only one for Individual #81 for a total of 23 for this review. Seventy percent of the SAPs were judged to be measurable (e.g., Individual #83's coin counting SAP). An example of a SAP that was judged to not be measurable was Individual #26's remain on task SAP because it was unclear how many prompts he could or should have to remain on task.

3-4. Sixty-five percent of the SAPs were clearly based on assessment results (e.g., Individual #81's FSA indicated that he required assistance to shave, therefore, a shaving SAP was developed). Several SAPs, however, did not have documentation that they were based on a demonstrated need or preference (e.g., Individual #161's dressing SAP), or assessment data suggested that the individual already had the skill (e.g., Individual #60's operate the radio SAP). Similarly, only 39% of SAPs were judged to be practical and meaningful. The SAPs that were judged not to be practical or functional typically appeared to represent a compliance issue rather than a new skill (e.g., Individual #26's remain on task SAP), or available assessment information suggested that the individual already demonstrated the skill (e.g., Individual #153's making his bed SAP), or the SAP did not appear to represent the acquisition of a skill (e.g., the objective of Individual #1's wipe her hands SAP was for her to use the wipe with full physical guidance from staff).

5. None of the 23 SAPs reviewed had interobserver agreement (IOA) demonstrating that the data were reliable. The Monitoring Team observed several SAPs being implemented and found that three (Individual #153's and Individual #83's remain on task SAPs and Individual #1's use wipes SAP) were scored correctly and, therefore, those were scored as having reliable data, despite the absence of IOA. Other SAPs observed, however, were not reliability recorded (e.g., Individual #60's SAP to fold pillowcases). Additionally, for several SAPs, the available raw data and data in the QIDP monthly report were not consistent (e.g., Individual #81's SAP to shred paper). The best way to ensure that SAP data are reliable is to regularly assess interobserver reliability (IOA), and assure that accurate data are reported in the QIDP monthly report.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	67% 6/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1

Comments:

10-11. All nine individuals had current FSAs, PSIs, and vocational assessments. These assessments, however, were not as useful as they could be because none of individuals had all these assessments available to the IDT at least 10 days prior to their ISP (e.g., Individual #26's PSI, Individual #200's vocational assessment, Individual #153's FSA). El Paso SSLC indicated that PSIs were not due until 10 days following the ISP. That policy, however, would result in the PSIs not being useful for the development of the ISP, therefore, they were rated as late if they, like the FSAs and vocational assessments, were not available to the IDT at least 10 days prior to the IDT.

12. The majority of individual's reviewed had both vocational and functional skills assessments that included SAP recommendations. The exceptions were Individual #83 and Individual #81's FSAs did not contain SAP recommendations, and Individual #200's vocational assessment did not contain SAP recommendations.

Domain #3: Individuals in the Target Population will achieve optimal physical, mental, and behavioral health and well-being through access to timely and appropriate clinical services.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score	#200	#26	#153						
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 3/3	1/1	1/1	1/1						
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 3/3	1/1	1/1	1/1						
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 3/3	1/1	1/1	1/1						
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	67% 2/3	0/1	1/1	1/1						
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/3	0/1	0/1	0/1						
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	0% 0/3	0/1	0/1	0/1						

	them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	67% 2/3	0/1	1/1	1/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	33% 1/3	0/1	1/1	0/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	100% 1/1	N/A	1/1	N/A						
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 3/3	1/1	1/1	1/1						
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	33% 1/3	0/1	0/1	1/1						

Comments:
18-29. This outcome and its indicators applied to Individual #200, Individual #26, and Individual #153.

21. The minutes of Individual #200's ISPA did not reflect a discussion of contributing environmental variables.

22. There was documentation in the ISPA of a discussion among the IDT of potential environmental antecedents to Individual #26's restraint, however, no plans or action to address those antecedents were documented. The minutes of the Individual #200's and Individual #153's ISPAs did not reflect a discussion of contributing environmental antecedents for their restraints.

23. There was documentation in the ISPA of a discussion among the IDT of potential variables (e.g., gaining access to tangible reinforcers) contributing to Individual #26's restraint, however, no plans or action to address those maintaining variables were documented. The minutes of Individual #200 and Individual #153's ISPAs did not reflect a discussion of contributing maintaining variables for their restraints.

24. Individual #200's PBSP was not current (dated 3/14).

25. Individual #200 and Individual #153 did not have a CIP.

29. The IDT reviewed the Individual #200's PBSP and suggested revisions, but these did not occur. There was no evidence in Individual #26's ISPA that the IDT reviewed his PBSP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
1	If not receiving psychiatric services, a Reiss was conducted.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 1. For the 16 individuals reviewed by both Monitoring Teams, all but two were receiving psychiatric services. A Reiss screen was conducted for both (Individual #1, Individual #5). 2. The Reiss screen for Individual #1 in October 2012 resulted in a psychiatric evaluation but, ongoing treatment was not necessary. Since that time, she experienced serious health conditions, including a long-term hospitalization. Therefore, a Reiss screen should have been conducted at that time for a change of status. A Reiss should be done after a major event/change of status of any kind that could result in psychiatric symptoms or that might provoke an emotional response.										

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 8-9. This outcome is concerned with the individual's general clinical status and stability. Without measurable goals and objectives,											

progress could not be determined. Thus, the first two indicators were scored at 0%. That being said, one of the individuals was reported to be doing well psychiatrically (Individual #60). This was based upon information in the record and observation of this individual's psychiatric clinic during the monitoring visit. With regard to the other individuals, it is recognized that the record may be an inadequate reflection of these individuals' status.

10-11. Despite the absence of measurable goals it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	75% 6/8	0/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	17% 1/6	0/1	N/A	0/1	0/1	0/1	0/1	1/1	N/A	N/A

Comments:
This outcome relates to the coordination of treatment between psychiatry and behavioral health services.

23. Although there was consistency in the derivation of the target behaviors, there were concerns regarding the validity of target symptoms identified in both documents. That is, the target symptoms did not correspond with a specific diagnosis.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	63% 5/8	0/1	N/A	1/1	1/1	1/1	0/1	1/1	1/1	0/1
26	Frequency was at least annual.	100% 7/7	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	63% 5/8	0/1	N/A	1/1	1/1	1/1	0/1	1/1	1/1	0/1

Comments:
This outcome addresses the coordination between psychiatry and neurology. These indicators applied to eight of the individuals.

25-27. There was a separate progress note authored by psychiatry for individuals participating in the combined neuropsychiatry clinic held at the facility (five of the eight individuals). In general, psychiatry did a good job of documenting the neurological information. Given that the facility had a period of time in late 2014 and early 2015 where there was no psychiatric provider, the neurologist had to make some psychiatric medication adjustments in the absence of psychiatry consultation.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
33	Quarterly reviews were completed quarterly.	38% 3/8	1/1	N/A	0/1	0/1	1/1	1/1	0/1	0/1	0/1
34	Quarterly reviews contained required content.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments:
33. There were five individuals who had delinquencies with regard to completion of quarterly psychiatric clinics. This was likely due to a vacancy in the psychiatry clinic.

34. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. In order to obtain an accurate reflection of the current state of psychiatric services, documentation authored by the current provider was utilized for this part of the review. In general, documentation was complete with a need for improvement regarding one component: the implementation of non-pharmacological interventions.

35. Psychiatric clinic observed for Individual #60 was well run and included good discussion among attendees, led and facilitated by the psychiatrist.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	38% 3/8	0/1	N/A	1/1	1/1	1/1	0/1	0/1	0/1	0/1

Comments:
36. In general, these assessments were performed in a timely manner and reviewed by the psychiatrist within 15 days. There were some delays, likely due to inconsistent psychiatric staffing, which resulted in most of the individuals not meeting criterion on this

indicator.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 4/4	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 4/4	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 4/4	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A
Comments: 37-39. There was evidence of frequent additional psychiatric reviews when an individual was clinically unstable. These documents were generally handwritten and titled as a face-to-face assessment.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	75% 6/8	0/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 40-43. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment. The facility did not use PEMA. 42. Individual #161 and Individual #8's PBSPs were out of date.											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	86% 6/7	1/1	N/A	1/1	0/1	1/1	1/1	1/1	1/1	N/A
45	There is a tapering plan, or rationale for why not.	100% 6/6	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1	N/A
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	71% 5/7	1/1	N/A	1/1	1/1	1/1	1/1	0/1	0/1	N/A
Comments: 44-46. The facility psychiatrist did a good job of justifying polypharmacy. There was need for improvement with regard to documentation of the polypharmacy review committee.											

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
6	The individual is making expected progress	1/5 20%	0/1	N/A	0/1	1/1	0/1	N/A	0/1	N/A	N/A
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	25% 1/4	1/1	N/A	0/1	N/A	0/1	N/A	0/1	N/A	N/A
9	Activity and/or revisions to treatment were implemented.	1/1 100%	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 6. A determination of progress was not possible for Individual #153 because his progress note only included two months of PBSP data. Progress note data from the remaining five individuals with PBSP data suggested that only Individual #200 was progressing at the time of the onsite review.											

7. Progress notes indicated that Individual #8 achieved his clothes ripping objective in January 2015, however, no activity (e.g., development of new or revised objectives) was evident.

8. Four individuals were noted to not be making progress. Individual #161's note suggested the use of sensory activities to address her absence of progress, however, Individual #8, Individual #26 and Individual #81's progress notes did not address suggested actions to be taken to address their lack of progress.

9. There was evidence that Individual #161's sensory activities suggestion in her progress note was implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0/6 0%	0/1	N/A	0/1	0/1	0/1	0/1	0/1	N/A	N/A
17	There was a PBSP summary for float staff.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	67% 4/6	1/1	N/A	1/1	0/1	1/1	1/1	0/1	N/A	N/A

Comments:

16. None of the individuals' treatment sites had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing PBSPs were in fact trained on their PBSPs.

17. El Paso SSLC utilized a brief PBSP all individuals for DSPs.

18. Individual #200's PBSP and Individual #81's functional assessment were written by a behavioral specialist who was enrolled in BCBA coursework, however, neither was signed by a BCBA.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
19	The individual's progress note comments on the progress of the individual.	33% 2/6	0/1	N/A	1/1	1/1	0/1	0/1	0/1	N/A	N/A
20	The graphs are useful for making data based treatment decisions.	50% 3/6	1/1	N/A	1/1	0/1	0/1	0/1	1/1	N/A	N/A

21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%	This is a facility indicator; it was scored yes.								

Comments:

19. All the progress notes commented on progress, however Individual #161, Individual #26, and Individual #153's records were missing some monthly notes, and Individual #81's note contained comments that were not consistent with the data presented.

20. All individuals reviewed had graphed PBSP data that were clearly presented with phase change lines. Three individual's graphs (Individual #200, Individual #26, Individual #153), however, did not fully note important environmental changes (e.g., medication changes).

21. The Monitoring Team observed one psychiatric clinic meeting. In Individual #60's quarterly psychiatric review, current data (from her psychiatric support program) were presented and graphed.

22-23. The Monitoring Team observed a peer review meeting that included the review of the functional assessments and PBSPs of an individual that was not progressing as expected. There was excellent participation and discussion by the team to improve the individual's program. The Monitoring Team was particularly impressed by the presentation of Individual #1's skill acquisition plans (an individual who does not have a PBSP), focusing on improving her functional skills. It was encouraging to see that El Paso SSLC was expanding peer review to include the review and improvement of all treatment plans; those to increase desired behaviors as well as those designed to reduce maladaptive behaviors.

Outcome 8 – Data are collected correctly and reliably.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A

29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A
30	If the individual has a PBSP, goal frequencies and levels are achieved.	50% 3/6	0/1	N/A	1/1	1/1	1/1	0/1	0/1	N/A	N/A

Comments:
26-27. The data collection system for target and replacement behaviors was adequate.

28. There were established measures of IOA, data collection timeliness, and treatment integrity.

29. El Paso SSLC had established a schedule (once a month) and minimal level (80%) of IOA, data collection timeliness, and treatment integrity for each individual's PBSP.

30. All of the individuals had IOA, data collection timeliness, and treatment integrity data that were collected monthly and were consistently above 80%. Individual #161's progress note, however, questioned the reliability and validity of her PBSP data. Additionally, Individual #153 and Individual #81's progress notes indicated that, despite the high treatment integrity scores, the behavioral health services staff believed that their PBSPs were not regularly implemented as written.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	28% 5/18	2/2	0/2	1/2	0/2	1/2	0/2	0/2	1/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	28% 5/18	2/2	0/2	1/2	0/2	1/2	0/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	17% 3/18	0/2	0/2	1/2	0/2	1/2	0/2	0/2	1/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	17% 3/18	0/2	0/2	1/2	0/2	1/2	0/2	0/2	1/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/15	0/2	0/2	0/1	0/2	0/1	0/2	0/2	0/1	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #90 – aspiration, and osteoporosis; Individual #123 – diabetes, and cardiac disease; Individual #13 – seizures, and diabetes; Individual #119 – gastrointestinal problems, and osteoporosis; Individual #161 – seizures, and circulatory; Individual #5 – diabetes, and osteoporosis;

Individual #59 – other: hypertension, and seizures; Individual #24 – seizures, and osteoporosis; and Individual #1 – cardiac disease, and respiratory compromise). Five of the goals/objectives were clinically relevant and achievable, and measurable, including Individual #90 – aspiration, and osteoporosis; Individual #13 – seizures; Individual #161 – circulatory; Individual #24 – seizures.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. The exceptions were for the following for which data was included in ISP progress reports: Individual #13 – seizures, Individual #161 – circulatory, and Individual #24 – seizures (who had a goal to remain seizure free; she had been free of seizures since 2011). As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
g.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1
	ii. Colorectal cancer screening	100% 5/5	1/1	1/1	N/A	N/A	N/A	1/1	1/1	N/A	1/1
	iii. Breast cancer screening	100% 5/5	N/A	1/1	N/A	1/1	1/1	N/A	N/A	1/1	1/1
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 5/5	N/A	1/1	N/A	1/1	1/1	N/A	N/A	1/1	1/1
h.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	Not Rated									
Comments: g.i. through g.vii. The nine individuals reviewed generally had timely preventative screenings and care. Of note:											

- For Individual #59 and Individual #24, there was no documentation of varicella immunity other than date of birth. According to the Centers for Disease Control (CDC): "Vaccination should be considered for susceptible persons in the following groups who are at high risk for exposure: 1. Persons who live or work in environments in which transmission of Varicella-zoster virus (VZV) is likely (e.g., teachers of young children, day-care employees, and residents and staff in institutional settings)." Furthermore, per the CDC: "birth in the United States before 1980 should not be considered evidence of immunity for health care personnel, pregnant women and immuno-compromised person."
- In addition, Individual #59 had a history of latent tuberculosis infection (LTBI) dating back to 2012. Facility staff submitted documentation indicating that a local health department physician and a Department of State Health Services (DSHS) physician concurred that the individual should not be treated. A third opinion was obtained from a board certified Infectious Disease specialist reported to be a "CDC consultant." The recommendation from that physician was to treat based on the fact that the individual lived in a congregate setting. The individual was not being treated at the time of record review.
- Individual #123 was on Prolia. Her last bone mass density test was done in 2010. Although bone mineral density tests had been attempted and were unsuccessful, there was no discussion of other methods of obtaining and following bone mineral density that may be performed for individuals who are difficult to study while on Prolia. Since the individual is receiving pharmacologic therapy, there should be some means of determining the effectiveness of the therapy.

h. This indicator was not rated during this review, but will be during upcoming reviews.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual with DNR that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: None.

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	33% 5/15	1/2	0/2	1/1	1/1	1/2	1/2	0/2	0/2	0/1

b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	13% 2/15	0/2	0/2	1/1	0/1	0/2	1/2	0/2	0/2	0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	60% 3/5	N/A	N/A	N/A	N/A	0/2	N/A	1/1	N/A	2/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2/2
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 5/5	N/A	N/A	N/A	N/A	2/2	N/A	1/1	N/A	2/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 5/5	N/A	N/A	N/A	N/A	2/2	N/A	1/1	N/A	2/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 2/2	N/A	N/A	N/A	N/A	2/2	N/A	N/A	N/A	N/A
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	60% 3/5	N/A	N/A	N/A	N/A	1/2	N/A	1/1	N/A	1/2
Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 15 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #90 (dehydration on 5/14/15, and aspiration pneumonia on 5/14/15), Individual #123 (pneumonia on 7/31/15, and UTI on 7/10/15), Individual #13 (chemical conjunctivitis on 6/1/15), Individual #119 (rule out retinal detachment on 8/4/15), Individual #161 (conjunctivitis on 5/28/15, and nasal fracture on 6/15/15), Individual #5 (cough on 4/16/15, and persistent cough on 5/15/15), Individual #59 (medication error on 7/2/15, and laceration on 8/7/15), Individual #24 (pancreatitis on 8/3/15, and gastritis on 5/7/15), and Individual #1 (eschar coccyx). For the following acute issues, medical providers at El Paso SSLC followed accepted clinical practice in assessing them: Individual #90 (aspiration pneumonia on 5/14/15), Individual #13 (chemical conjunctivitis on 6/1/15), Individual #119 (rule out retinal detachment on 8/4/15), Individual #161 (conjunctivitis on 5/28/15), and Individual #5 (persistent cough on 5/15/15). For the following individuals, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent										

with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #13 (chemical conjunctivitis on 6/1/15), and Individual #5 (persistent cough on 5/15/15).

The following provide examples of some of the problems noted with regard to the assessment and treatment of individuals at El Paso SSLC:

- For Individual #90, on 4/29/15, the PCP documented the individual had decreased responsiveness and a blood sugar of 213. The blood pressure was noted to be 90/60, with oxygen saturations ranging between 88% and 92%. D5NS (i.e., fluid) was ordered in addition to a chest x-ray and labs. Nursing documentation indicated that the fluid administered was D5W (not D5NS). The PCP did not document any follow-up assessment of this individual who was lethargic and hypotensive. On 5/4/15, the PCP noted loose stools and indicated the individual was dehydrated. The plan was to check a Clostridium difficile (CDiff) toxin, give additional water, and check labs the next day. There was no further documentation.
- On 7/31/15, Individual #123 was seen in the clinic due to complaints of a cough. Robitussin was prescribed and the plan was to monitor closely. On 8/3/15, a follow-up assessment was documented and it was noted that a chest x-ray would be ordered because of large airway congestion. On 8/4/15, the PCP documented that the chest x-ray showed a right-lung pneumonia. Levaquin for started with the plan to obtain a repeat x-ray in 10 days. There was no further follow-up documented in the records.
- On 4/16/15, Individual #5 was referred to the clinic due to a dry, hacking cough that started that day. Allergic bronchitis was the diagnosis, and the individual was treated with antihistamines and Robitussin. There was no follow-up documented. On 5/15/15, the individual returned to clinic for evaluation by another PCP at which time a dry cough for several months was documented. The individual's ACE inhibiter was discontinued, and follow-up in two to three weeks was the plan. On 5/19/15, he was seen again with a continued cough. On 6/5/15, it was documented that the cough had subsided.
- On 7/2/15, the PCP evaluated Individual #59 for right foot edema noting that the individual was being monitored due to a medication error (i.e., received another individual's medications). It was documented that the individual was drowsy, very lethargic but arousable. Oxygen saturation was 86% on room air but increased to 94% with oxygen. Respiratory documented at 10:45 p.m. that the individual was lethargic with shallow respirations. The PCP did not document any additional clinical information, such as what medications were administered, what the potential side effects were, or if additional treatment was warranted. There was no documentation that poison control was contacted.
- On 8/7/15, the PCP saw Individual #59 who fell and hit head the previous day. Steri strips were applied at that time. The PCP documented a 2.5-centimeter laceration on the left forehead. However, the documentation related to the fall lacked adequate information, such as history of loss of consciousness, and history of nausea or vomiting after the event, which are necessary in the evaluation of someone with head trauma. The plan was for follow-up in three days, but no follow-up was documented in the records. There as also no plan to monitor for signs or symptoms associated with head trauma.
- On 8/3/15, the PCP evaluated Individual #24 due to complaints of urinary frequency. Labs obtained showed an elevated lipase of 422. The diagnosis of mild pancreatitis was made. There was no physician follow-up until 8/12/15, at which time the individual complained of a headache and emesis. Gastritis was the diagnosis. Treatment was with Phenergan and a clear liquid diet. Labs were ordered. On 8/21/15 and 8/20/15, the individual was seen in the clinic. The lipase level increased, so an ultrasound was ordered to appropriately rule out gallstones.
- For Individual #1's eschar coccyx, there was no follow-up assessment or discussion related to wound healing. An eschar might represent a stage of healing or might be present as part of an unhealed wound. Further medical evaluation was warranted, and

there was no documentation that any follow-up assessment occurred.

c. Five acute illnesses requiring hospital admission or ED visit were reviewed including the following with dates of occurrence: Individual #161 (seizures on 7/31/15, and apnea/code blue on 7/24/15), Individual #59 (loss of consciousness on 5/14/15), and Individual #1 (respiratory failure on 6/11/15, and hypertensive episode on 6/10/15).

d. Three of the acute illnesses reviewed occurred after hours or on a weekend/holiday. For the remaining acute illnesses, it was positive that Individual #1 had a quality assessment documented in the IPN.

e. through g. For the acute illnesses reviewed, it was positive the individuals received timely treatment at the SSLC; for the individuals that were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff; and as appropriate, the IDTs met and developed post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness.

h. For Individual #161 (seizures on 7/31/15), and for Individual #1 (respiratory failure on 6/11/15), evidence was not found that PCPs conducted follow-up assessments and documentation initially upon return to the Facility, as well as in accordance with the individuals' status and presenting problem through to resolution of the acute illness. More specifically:

- On 6/18/15, Individual #1 returned to the Facility. On 6/18/15, there was a post-hospital evaluation. This note did not address the assessment of the treating/consulting physicians that indicated that the acute on chronic respiratory failure was likely due to obesity/hypoventilation syndrome and sleep apnea. There was no further follow-up.
- Individual #161 was transferred to the ED due to seizure activity lasting five minutes. On 8/5/15, she returned to the Facility. The PCPs assessment was seizure disorder and skin disruption (right medial buttocks with 1.5 centimeter excoriation). The plan was to continue Keppra and apply DuoDerm to skin. There was no further documentation related to the skin issue. The next PCP entry was dated 8/10/15. The PCP also did not address issues related to increasing seizure activity and the contributing factors.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	88% 15/17	2/2	1/2	2/2	1/2	1/2	1/1	2/2	2/2	2/2

b.	PCP completes review within five business days, or sooner if clinically indicated.	71% 12/17	2/2	0/2	2/2	1/2	1/2	1/1	2/2	1/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	94% 16/17	2/2	1/2	2/2	2/2	2/2	1/1	2/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 16/16	2/2	1/1	2/2	2/2	2/2	1/1	2/2	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #90 for pulmonary on 5/11/15, and gastrointestinal (GI) on 3/6/15; Individual #123 for ophthalmology on 7/15/15, and GI on a date unknown; Individual #13 for ophthalmology on 6/22/15, and neurology on 7/25/15; Individual #119 for ophthalmology on 8/5/15, and orthopedics on 6/18/15; Individual #161 for GI on 6/22/15, and ear, nose, and throat (ENT) on 8/26/15; Individual #5 for neurology on 4/29/15; Individual #59 for neurology on 8/18/15, and GI on 4/9/15; Individual #24 for GI on 7/7/15, and ophthalmology on 5/22/15; and Individual #1 for renal on 4/3/15, and pulmonary on 4/22/15.

a. It was positive that for the individuals reviewed, PCPs generally reviewed and initialed consultation reports, and indicated agreement or disagreement with the recommendations. The exceptions were for Individual #123 for GI on a date unknown, and Individual #161 for GI on 6/22/15.

b. The reviews that were not timely were those for Individual #123 for ophthalmology on 7/15/15, and GI on a date unknown; Individual #119 for orthopedics on 6/18/15; Individual #161 for GI on 6/22/15; and Individual #24 for ophthalmology on 5/22/15.

c. The consultation for which the PCP did not write a corresponding IPN that included the information that State Office policy requires was for Individual #123 for GI on a date unknown.

d. It was good to see that when PCPs agreed with consultation recommendations, there was evidence they were ordered.

e. For Individual #123 for the GI consultation on a date unknown, the PCP made an IPN entry indicating the GI recommendation was for a colonoscopy. There was no summary of the consult. Therefore, the reason for the colonoscopy was unknown. The PCP disagreed and referred it to the IDT. No ISPA documentation related to this was submitted. No GI consult was in the record.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	83% 15/18	1/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #90 – aspiration, and osteoporosis; Individual #123 – diabetes, and cardiac disease; Individual #13 – seizures, and diabetes; Individual #119 – gastrointestinal problems, and osteoporosis; Individual #161 – seizures, and circulatory; Individual #5 – diabetes, and osteoporosis; Individual #59 – other: hypertension, and seizures; Individual #24 – seizures, and osteoporosis; and Individual #1 – cardiac disease, and respiratory compromise).

a. Medical assessment, tests, and evaluations consistent with current standards of care were not completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #90 – aspiration, Individual #13 – diabetes, and Individual #1 – respiratory compromise.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	61% 11/18	1/2	1/2	1/2	1/2	2/2	2/2	1/2	1/2	1/2

Comments: a. For the individuals' chronic conditions/at-risk diagnoses reviewed, evidence was not found of thorough implementation of the medical interventions, including specific data to show their efficacy, for the following conditions: Individual #90 – aspiration, Individual #123 – cardiac disease, Individual #13 – diabetes, Individual #119 – GI problems, Individual #59 – other: hypertension, Individual #24 – osteoporosis, and Individual #1 – respiratory compromise. The following provide some examples of problems noted:

- Per Individual #90's AMA, in 2014, he had a history of pneumonia, and on 1/20/15, he was seen in the ER with pneumonia. From 2/6/15 to 2/9/15, he was hospitalized with pneumonia. On 5/14/15, the IPN documented a diagnosis of aspiration pneumonia, and on 5/26/15, coughing episodes and emesis. None of the PCP documentation addressed the issue of recurrent aspiration and what additional supports would be implemented.
- Per Individual #119's AMA, she had a diagnosis of gastroesophageal reflux disease (GERD), and received treatment with omeprazole and sucralfate. The last GI consult was in 2012. The PCP documented that the medications were discontinued and the esophagogastroduodenoscopy (EGD) report would be obtained. It was not clear why the medications were discontinued prior to obtaining the necessary records.
- Individual #1 was oxygen dependent and received continuous oxygen. In June 2015, she was hospitalized with acute on

chronic respiratory failure. The hospital notes indicated this was likely due to obesity hypoventilation syndrome/sleep apnea. The IPN medical documentation and Quarterly Medical Summary did not reflect this diagnosis, which was stated multiple times in hospital records. The individual was noted to have significant oxygen desaturation at night while sleeping.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1

Comments: a. and b. For the nine individuals reviewed, a total of 18 newly prescribed medications were reviewed. However, the document request specifically stated to submit documentation of "new medication orders," but the Facility counted discontinued orders in the sample of five. Overall, this decreased the number of new orders available for review. Based on this limited review, it was good to see that the Pharmacy Department completed reviews prior to dispensing the medications, and as necessary notified the prescribing providers of necessary interventions.

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 16/16	2/2	N/A	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 16/16	2/2	N/A	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 12/12	2/2	2/2	N/A	2/2	2/2	N/A	N/A	2/2	2/2
	v. Anticholinergic burden.	89% 16/18	2/2	2/2	2/2	2/2	2/2	0/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 14/14	2/2	2/2	2/2	2/2	2/2	N/A	2/2	2/2	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	88% 22/25	2/3	3/3	2/3	2/2	3/3	1/2	3/3	2/2	4/4

Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals. It was positive that all of the individuals reviewed had current QDRRs.

b. Overall, the QDRRs included valuable and thorough information. Individual #5's QDRRs did not address anticholinergic burden.

c. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations.

d. Evidence was not found to show that agreed-upon recommendations from the following QDRRs and/or new interventions were implemented timely: a recommendation in Individual #90's QRRR to obtain overdue labs for Hemoglobin (Hb) A1c and lipid panel, for which the PCP did not write orders until seven weeks after signing the QDRR (i.e., the QDRR was signed on 7/10/15, and the orders written on 8/24/15); for Individual #13, a recommendation in his QDRR to obtain thyroid stimulating hormone (TSH) levels (i.e., last was 1/9/15) and annual Hba1c (i.e., last in 2013 was abnormal); and for Individual #5, recommendations for overdue labs in his QDRR including TSH, and lipids, as well as a diabetic evaluation by podiatry.

Of concern were two medication variances that were not reported. More specifically:

- Individual #90's PCP wrote an order for Levofloxacin to be administered by mouth, but the individual was to have a nothing by mouth. This was a prescribing error, which should have been reported as a variance.
- The PCP for Individual #13 wrote an order for eye drops every two weeks instead of every two hours. This was not reported as a variance.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk ratings. None of these individuals' dental goals/objectives were clinically relevant and achievable, and/or measurable.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these individuals.

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	38% 3/8	1/1	N/A	1/1	0/1	0/1	0/1	1/1	0/1	0/1
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	63% 5/8	1/1	N/A	1/1	1/1	0/1	0/1	1/1	1/1	0/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	Not Rated									
e.	If the individual has need for restorative work, it is completed in a timely manner.	40% 2/5	0/1	N/A	1/1	N/A	0/1	N/A	1/1	N/A	0/1
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: e. The following concerns were noted with regard to restorative work:

- On 8/18/14, Individual #90 saw the community dentist who documented the need for hospitalization for treatment. That did not occur until 7/30/15, at which time the individual had 11 fillings, four-quadrant gingivectomy, and one extraction. A copy of the operative report was not submitted. As a result, the Monitoring Team could not verify the actual findings of the treating dentist, only the treatment provided.
- For Individual #161, in January 2015, the dentist identified the need for multiple restorations. At the time of the review, they had not been completed. Individual #161 requires general anesthesia for the treatment to be completed.
- On 10/28/13, the dentist saw Individual #1 and determined that general anesthesia was needed for gum treatments, x-rays, exam, extractions, and filings. A 6/5/14 appointment was cancelled. At the time of the review, Individual #1 had not had the needed dental treatment.

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	0% 0/1	0/1								

b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A	N/A								
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	0% 0/1	0/1								
Comments: a. through c. On 6/17/15, Individual #90 was seen in the clinic because he hit himself in chin. The dentist was not available. The Registered Dental Hygienist saw him. On 7/6/15, the dentist saw him, and documented a limited exam due to lack of cooperation. The exam was attempted again on 7/8/15, and was documented as limited. At the time of the incident, he did not have an evaluation by a dentist or a medical provider. There was no documentation in the IPNs related to pain management. On 7/30/15, Individual #90 had full mouth rehabilitation.											

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 3/3	1/1				1/1				1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 3/3	1/1				1/1				1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3	0/1				0/1				0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3	0/1				0/1				0/1
Comments: None											

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	44% 4/9	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
Comments: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	50% 5/10	0/2	0/2			2/2	1/1	1/1		1/2
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	22% 2/9	0/2	0/1			0/2	0/1	1/1		1/2
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/7	0/2	0/2			0/1	0/1	N/A		0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	33% 1/3	N/A	N/A			0/1	N/A	1/1		0/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/10	0/2	0/2			0/2	0/1	0/1		0/2
f.	The individual's acute care plan is implemented.	0% 0/10	0/2	0/2			0/2	0/1	0/1		0/2

Comments: The Monitoring Team reviewed 10 acute illnesses and/or acute occurrences for six individuals, including Individual #90 for dehydration and high blood sugar on 4/29/15, and hyperpyrexia, bronchospasm, dehydration/pneumonia on 5/14/15; Individual #123 – urinary tract infection (UTI) on 3/18/15, and UTI/rule/out pneumonia on 3/18/15; Individual #161 – vomiting on 3/13/15, and nasal fracture associated with fall on 6/13/15; Individual #5 – allergies/bronchitis on 4/16/15; Individual #59 – change in level of consciousness/hypoxia on 5/14/15; and Individual #1 – eschar coccyx on 4/30/15, and acute Hypoxia/Hypertensive Crisis, Urinary Retention, and Constipation on 6/10/15.

b. This indicator was not applicable for Individual #123's UTI, because there was no documentation leading up to the order from the physician to collect a sample for a urinalysis, so it could not be determined whether or not notification was necessary. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #59 – change in level of consciousness/hypoxia on 5/14/15; and Individual #1 – acute Hypoxia/Hypertensive Crisis, Urinary Retention, and Constipation on 6/10/15.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #59 – change in level of consciousness/hypoxia on 5/14/15.

e. In a number of cases, an acute care plan should have been developed, but was not. For those that were developed, problems included, for example, plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure; and not identifying the frequency with which monitoring should occur.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	17% 3/18	0/2	0/2	0/2	2/2	0/2	0/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #90 – UTIs, and fluid imbalance; Individual #123 – skin integrity, and UTIs; Individual #13 – constipation/bowel obstruction, and seizures; Individual #119 – gastrointestinal problems, and constipation/bowel obstruction; Individual #161 – gastrointestinal problems, and constipation/bowel obstruction; Individual #5 – gastrointestinal problems, and constipation/bowel obstruction; Individual #59 – UTIs, and infections; Individual #24 – constipation/bowel obstruction, and gastrointestinal problems; and Individual #1 – skin integrity, and respiratory compromise). None of the IHCPs included clinically relevant, and achievable goals/objectives. The goals/objectives that were measurable were for Individual #119 – gastrointestinal problems, and constipation/bowel obstruction; and Individual #24 – constipation/bowel obstruction.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of

nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/8	0/1	0/1	N/A	N/A	N/A	0/1	0/2	0/1	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.

a. For the individuals reviewed, evidence was not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner. For individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs due to the lack of inclusion of regular assessments in alignment with nursing protocols. As a result, data were not available to show implementation of such assessments.

b. For the following individuals' risks, IDTs should have taken immediate action, but did not: Individual #90 for fluid imbalance; Individual #123 for UTIs; Individual #5 for constipation; Individual #24 for UTIs, and infections; Individual #24 for gastrointestinal problems; and Individual #1 for skin integrity, and respiratory compromise. Individuals experienced exacerbations of their risk conditions, but ISPAs were not found showing that teams took actions to address individuals' change in status.

c. Generally, for the individuals reviewed, documentation was not available to show their nursing interventions were implemented thoroughly. The exception was Individual #13's IHCP related to constipation/bowel obstruction for which daily documentation was completed on flow sheets, including nursing staff's review of the data.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed here.]	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual receives prescribed medications in accordance with applicable standards of care.	80% 16/20	1/2	2/2	1/2	2/2	1/2	1/1	2/2	1/1	1/2

b.	Medications that are not administered or the individual does not accept are explained.	60% 3/5	N/A	1/1	0/1	N/A	0/1	N/A	N/A	1/1	1/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 10/10	1/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual's PNMP plan is followed during medication administration.	100% 9/9	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	82% 9/11	0/1	1/1	1/1	1/1	0/1	N/A	1/1	N/A	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	63% 5/8	0/1	1/1	0/1	1/1	0/1	N/A	1/1	1/1	1/1
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/2	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A
		Individuals:									
#	Indicator		#34	#12	#9	#49					
a.	Individual receives prescribed medications in accordance with applicable standards of care.		1/1	1/1	1/1	1/1					

b.	Medications that are not administered or the individual does not accept are explained.		N/A	N/A	N/A	N/A					
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).		1/1	1/1	1/1	1/1					
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.		N/A	N/A	N/A	N/A					
e.	Individual's PNMP plan is followed during medication administration.		1/1	1/1	N/A	N/A					
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.		1/1	1/1	1/1	1/1					
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.		N/A	N/A	N/A	N/A					
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.		N/A	N/A	N/A	N/A					
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.		N/A	N/A	N/A	N/A					
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.		N/A	N/A	N/A	N/A					
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.		N/A	N/A	N/A	N/A					
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.		N/A	N/A	N/A	N/A					

Comments: The Monitoring Team conducted record reviews for nine individuals (i.e., Individual #90, Individual #123, Individual #13, Individual #119, Individual #161, Individual #5, Individual #59, Individual #24, and Individual #1) and observations of medication administration for 11 individuals (i.e., Individual #90, Individual #123, Individual #13, Individual #119, Individual #161, Individual #59, Individual #1, Individual #34, Individual #12, Individual #9, and Individual #49).

a. and b. During the onsite observations, individuals received their prescribed medications. In conducting record reviews, problems were found when individuals' Medication Administration Records (MARs) included blanks that had not been reconciled, or circled entries were not explained.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes nursing staff followed

the nine rights of medication administration.

d. For each of the individuals reviewed, nursing staff administered PRN medication, but did not document the individual's reaction.

e. It was positive that for the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs during the observations.

f. As discussed during the onsite review with the Chief Nursing Executive (CNE), Nursing Operations Officer (NOO), and Nursing Supervisor, infection control issues related to the use of gloves during administration, particularly G-tube medications.

g. For the records reviewed, evidence was not present to show that instructions were provided to the individuals and their staff regarding new orders or when orders changed.

h. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was not present to show individuals were monitored for possible adverse drug reactions.

i. and j. One of the common medication side effects of Linsopril, an ACE inhibitor, is a cough. On 4/14/15, nursing staff did refer Individual #5 to his physician for his dry cough, and he was ordered Robutussin for six days. However, no documentation on the back of the MARs or subsequent nursing IPNs were found for the six days to address his response to medication. On 5/16/15, the nursing IPN indicated the individual had no improvement with the Robitussin. On 5/16/15, he was seen in the clinic and Linsopril was discontinued.

k. The problems related to documentation of medication variances varied, but some examples included:

- MAR blanks were not reconciled and reported;
- Lack of identification of variance;
- Un-reconciled discrepancies; and
- Incorrect classification of variances.

l. Individual #59 experienced a serious medication variance, requiring the individual to have respiratory support (i.e., oxygen). The classification for this variance was incorrect. On 7/2/15 at 12:50 p.m., the individual's blood pressure was 90/58 with a pulse rate of 48. The nurse documented notification of the physician to give an "update." The record showed the blood pressure and pulse measurements were not taken again until 7/2/15 at 6:45 p.m. The record indicated the physician was notified of his progress, but it is unknown if his status concerning low blood pressure and pulse were reported. The Monitoring Team was concerned about the lapse of time between the vital sign measurements, given the low blood pressure and bradycardia (below 60) pulse. Vital signs should have been taken more frequently. Nursing staff should be retrained on interpreting the significance of vital signs.

An overall issue that was noted with the MARs and the Monitoring Teams discussed in detail with the CNE was related to the lack of continuity of the time periods MARs covered. Often, this appeared to be a function of a new medication being added in the middle of the MAR cycle. A new MAR would be started with the new medication added and the previous medications listed, but nursing staff would

not mark through the remaining dates on the old MAR with a notation that the new MAR should be used. This practice was wrought with potential for medication variances. As discussed with the CNE, when a new medication is ordered and the pharmacy prints a new MAR or when nursing staff transcribe a new medication, the previous MAR should not be left with multiple blanks for the same administration period, but rather should have unused dates marked through.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	13% 2/16	N/A	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	38% 6/16	N/A	0/2	2/2	0/2	0/2	1/2	1/2	2/2	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/16	N/A	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/16	N/A	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/16	N/A	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	67% 4/6	2/2	0/1	N/A	N/A	1/2	N/A	N/A	N/A	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/2	0/1	N/A	N/A	0/2	N/A	N/A	N/A	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6	0/2	0/1	N/A	N/A	0/2	N/A	N/A	N/A	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/2	0/1	N/A	N/A	0/2	N/A	N/A	N/A	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/2	0/1	N/A	N/A	0/2	N/A	N/A	N/A	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/2	0/1	N/A	N/A	0/2	N/A	N/A	N/A	0/1

Comments: a.i. and a.ii. The Monitoring Team reviewed 16 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and falls for Individual #123; choking, and falls for Individual #13; choking, and fractures for Individual #119; aspiration, and weight for Individual #161; choking, and falls for Individual #5; falls, and fractures for Individual #59; aspiration, and falls for Individual #24; and aspiration, and skin integrity for Individual #1. The goal/objective that was clinically relevant, achievable, and measurable was the one for aspiration for Individual #24. The ones that were measurable were those for choking, and falls for Individual #13; falls for Individual #5; falls for Individual #59; and aspiration, and falls for Individual #24.

b.i. The Monitoring Team reviewed six areas of need for four individuals that met criteria for PNMT involvement, including: aspiration, and weight for Individual #90; aspiration for Individual #123; aspiration, and weight for Individual #161; and aspiration for Individual #1. The following problems were identified related to referrals to the PNMT:

- Individual #123 was referred to PNMT, but this did not occur within five days of the qualifying event. She had aspiration pneumonia in early August, but the MD did not make this determination until 8/26/15, at which point she was referred. This appeared to be a trend. The PNMT documented their concerns that this process delays the initiation of their involvement, including assessment and development and implementation of supports/interventions. The evaluation for Individual #123 was in process at the time of the document request. However, had she been referred timely, goals/objectives and interventions should have been in place at the time of the review.
- Individual #161 was referred to the PNMT for aspiration. However, she also met criteria for referral for weight, but was not referred timely. She has been on a planned weight loss diet due to a history of obesity. In July 2013, her highest weight was 144.8 pounds, and in March 2014, her weight was 130 pounds. At time of her annual nutrition assessment on 3/23/15, she weighed 117.25 pounds. Continued gradual weight loss was recommended with a plan outlined. Her recommended range was

90 to 110 pounds with an ideal body weight of 100 pounds. Based on review of ISPAs, weight loss issues were documented in June to July, described as related to positioning and behavior issues as well as some indications of vomiting. Although the IDT discussed these concerns and implemented some interventions, it was not clear that they were effective and there was no evidence of referral to the PNMT at that time despite the fact that the criteria for weight had been met. According to the ISPA dated 7/20/15, she lost 8.4 pounds in one month. Although originally the weight loss was planned, it was not gradual and appeared to be associated with other concerns.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable, and/or measurable goals/objectives for these individuals.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	20% 1/5	0/1	0/1	N/A	N/A	0/2	N/A	N/A	N/A	1/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 2/2	2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. In addition, the timeframes and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion.

b. For Individual #90, although the IDT met to discuss and revise plans when he experienced changes in status, the PNMT did not conduct a timely comprehensive assessment. For Individual #123, a change of status review was not conducted until 8/26/15, weeks after the occurrence of pneumonia. For Individual #161, issues related to her weight and mealtime status were not addressed in a timely manner. On a positive note, for Individual #1, in June 2015 and again in August 2015, the IDT and PNMT met to review supports related to her hospitalizations.

c. The PNMT shared information with the IDT for aspiration, and weight issues for Individual #90.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	65% 53/81
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	44% 4/9
Comments: a. The Monitoring Team conducted 81 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 15 out of 26 observations (58%). Staff followed individuals' dining plans during 31 out of 40 mealtime observations (78%). Transfers were completed according to the PNMPs in six of 11 observations (55%). In none out of one observation of oral care (0%), staff followed the PNMP. Nurses followed the PNMPs in one of three medication administration observations (33%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/1	N/A				0/1				N/A
Comments: Individual #161 reportedly used the feeding tube only as needed, but there was no tracking of the use of the tube summarized in the ISP/ISPAs.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. For several individuals reviewed (i.e., Individual #90, Individual #119, Individual #161, Individual #5, Individual #59, Individual #24, and Individual #1), OT/PT assessments recommended OT/PT-related goal development (e.g., adaptive skills, exercise, etc.), but justification was not found in ISPs for not including the recommended goals/objectives.

Individual #123's goal/objective for ambulation and Individual #13's range of motion goal/objective were clinically relevant, achievable, but not measurable.

c. through e. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	11% 1/10	0/2	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. The following provide some examples of the problems noted:

- For Individual #90, no evidence was available to show that he was provided a radio for gait trainer per the PNMP (i.e., in its comments, the State indicated it could be seen in the PNMP picture of the gait trainer, but based on the copy provided, the Monitoring Team could not identify the box for the radio in the picture), and there was no evidence the hand-washing goal was implemented.

- For Individual #123, the document request indicated that direct therapy for ambulation was not recommended, despite it being included in the assessment and approved by the IDT.
- For Individual #5, the QIDP monthly report indicated no data was available for his OT/PT-related goal/program.

b. For Individual #123's program related to ambulation, and Individual #13's active range of motion program, it appeared that efforts were discontinued. However, there was no ISPA meeting documentation to show that the IDTs discussed and approved discharges.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.

			Individuals:								
#	Indicator	Overall Score	#93	#54	#6	#118	#129	#127	#25	#189	#103
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 20/20	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 20/20	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	70% 14/20	0/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1
		Individuals:									
#	Indicator		#46	#1	#24	#116	#82	#36	#28	#70	#40
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		#115	#4							
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1							
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1							
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1							

Comments: a. and b. The Monitoring Team conducted observations of 20 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment that was in working order, which was good to see.

c. Issues with proper fit were noted for six individuals. Based on observation of these individuals in their wheelchairs, the outcome was that they were not positioned correctly, or the wheelchair was not configured properly for self-propulsion (i.e., Individual #116, who propelled her wheelchair with her feet through the footrests). It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

Domain #4: Individuals in the Target Population will engage in meaningful activities, through participation in active treatment, community activities, work and/or educational opportunities, and social relationships consistent with their individual support plan.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#153	#81	#13	#119			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/5	0/6	0/6	N/A	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/5	0/6	0/6	N/A	0/6	0/6	0/6			

Comments:

4. Without measurable goals in place, it was not possible to determine if individuals were making progress toward achieving their goals. For a majority of the goals, there were not sufficient data to determine whether or not progress was being made.

6. Revisions to supports did not generally occur when individuals were not making progress (or if plans were not implemented). For example, Individual #81 and Individual #119's QIDPs indicated that they had not made progress on their personal goals. There was no documentation to show that the IDT met to discuss their lack of progress or revised the ISP to address any barriers to achieving outcomes. Individual #153 was a new admission and his ISP was not included in this indicator.

7. When revisions were made to supports, there was not sufficient data available to verify that changes were fully implemented.

Outcome 8 – ISPs are implemented correctly and as often as required.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#153	#81	#13	#119			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments:
39-40. A review of data sheets, QIDP monthly reviews, and observations while onsite did not support that action plans were being consistently implemented.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	153	#81	#83	#60
6	The individual is progressing on his/her SAPS	0% 0/20	0/2	0/2	0/3	0/3	0/3	N/A	0/1	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/11	N/A	0/2	0/2	N/A	0/1	N/A	0/1	0/2	0/3
8	If the individual was not making progress, actions were taken.	0% 0/3	N/A	N/A	N/A	N/A	0/2	N/A	N/A	0/1	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	6% 1/17	N/A	0/2	1/3	0/2	0/3	N/A	0/1	0/3	0/3

Comments:
6. Because good reliable data were not available, a determination of progress could not be made for the SAPs. That being said, the facility's reports showed that 20 of the 23 SAPs were progressing or met. Individual #153 was new to the facility and his ISP and SAPs were implemented less than three months ago.

7-9. Eleven SAP objectives were reported by the facility to have been achieved, however, all of these SAPs (e.g., Individual #83's remaining on task SAP) were continued. Similarly, in none of the three SAPs that were judged as not progressing (Individual #26's sort clothes and attend class, and Individual #83's identify numbers SAP), was there evidence that actions were taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there appeared to be data based decisions to continue, discontinue, or modify SAPs in just one of the SAPs reviewed (Individual #8's remain on task SAP was progressing and his SAP continued). The reasons the majority of SAPs were judged not to be examples of data based decisions were because individuals' achieved their SAP objective, but continued training on the SAP (e.g., Individual #1's SAP to use hand wipes), there was no progress for more than three months with no action (e.g., Individual #26's attend class SAP), or there were no data in the QIDP monthly report (e.g., Individual #200's make a sandwich SAP).

Outcome 4- All individuals have SAPs that contain the required components.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
13	The individual's SAPs are complete.	4% 1/23	0/2	0/2	0/3	0/3	1/3	0/3	0/1	0/3	0/3

Comments:

13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Only one of the 23 SAPs were judged as complete (Individual #26's SAP to sort his clothes). A common missing component was clear instruction for how to conduct the SAP. Many SAPs did not contain enough specific training detail for DSPs to implement them consistently. For example, Individual #26's remain on task SAP did not include how many prompts trainers should use to ensure that Individual #26 remains on task. A related common problem was the absence of specific instructions following an incorrect response. SAPs often had general instructions such as "do not over prompt," or "try again later," but lacked staff-specific instructions following an incorrect response, such as utilize least-to-most strategies, etc. Other SAP components missing or incomplete were task analyses (e.g., Individual #153's work on a task SAP), and generalization and/or maintenance plans (Individual #8's shampooing his hair SAP).

Outcome 5- SAPs are implemented with integrity.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
14	SAPs are implemented as written.	67% 4/6	N/A	1/1	N/A	0/1	N/A	1/1	N/A	1/2	1/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/23	0/2	0/2	0/3	0/3	0/3	0/3	0/1	0/3	0/3

Comments:

14. The Monitoring Team observed the implementation of six SAPs. Four were judged to be implemented with integrity (Individual #153 and Individual #83's remain on task SAP, Individual #60's folding pillowcases SAP, Individual #1's use hand wipes SAP). The other two SAPs observed by the Monitoring Team were not be implemented with integrity. The DSP implementing Individual #83's match numbers SAP combined verbal and gestural prompts, and then recorded them as verbal, while Individual #200's bed making SAP did not follow the task analysis, and utilized multiple levels of prompts, but not in any apparent systematic fashion (e.g., least-to-most, or most-to-least prompting).

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. At the time of the onsite review, El Paso SSLC did not conduct SAP integrity checks. It is suggested that the facility establish a frequency goal of checking the integrity of each SAP at least once every six months.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
16	There is evidence that SAPs are reviewed monthly.	52% 12/23	0/2	0/2	3/3	0/3	3/3	3/3	0/1	0/3	3/3
17	SAP outcomes are graphed.	0% 0/23	0/2	0/2	0/3	0/3	0/3	0/3	0/1	0/3	0/3

Comments:
16. Approximately half (52%) of SAP outcomes were reviewed in the QIDP monthly reviews and included SAP data (e.g., all three of Individual #60's SAPs). The other half of the SAPs were reviewed in QIDP meetings that were labeled as monthly meetings, but were all dated on the same date in September 2015 (e.g., all three of Individual #83's SAPs). These appeared to be more of a six-month progress note than a monthly review and, therefore, these were not rated as monthly meetings. Additionally, some monthly QIDP reports did not contain SAP data (e.g., all three of Individual #200's SAPs), thus, they were also not rated as monthly SAP reviews.

17. None of the SAPs reviewed were graphed. It is strongly recommended that monthly SAP data be consistently graphed in order to promote data based treatment decisions.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	3/7	4/5	3/6	3/4	2/8	3/3	2/6	4/4	4/6
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	22% 2/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments:
18-21. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found four (Individual #83, Individual #153, Individual #200, Individual #1) of the nine individuals (44%) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). El Paso SSLC conducted monthly engagement measures in all residential and day programming sites. Their established goal was 65% engagement (using a momentary sampling system to rate engagement that is similar to that used by the Monitoring Team).

The facility's engagement data indicated that the residential and day treatment sites of two of the individuals (Individual #1, Individual #26), achieved their goal level of engagement.

The Monitoring Team found the monitoring system used by the facility to be a sensitive measure of individual engagement. Although one would not expect 1:1 correspondence between the facility's engagement ratings and those of the Monitoring Team because the facility was measuring sites (i.e., residences, day programs) and the Monitoring Team was measuring individual engagement, the Monitoring Team found the facility ratings to be generally consistent with their observations of individual engagement.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.

			Individuals:								
#	Indicator	Overall Score	#161	#1	#8	#200	#26	#153	#81	#83	#60
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

Outcome 9 – Students receive educational services and these services are integrated into the ISP.

			Individuals:								
#	Indicator	Overall Score	171								
25	The student receives educational services that are integrated with the ISP.	100% 1/1	1/1								

Comments:

25. One individual at El Paso SSLC, Individual #171, was under age 22 at the time of the onsite review. Therefore, Individual #171 was included for this indicator. Individual #171 was admitted to El Paso SSLC towards the end of the last academic year, so he started receiving services from the local independent school district in September 2015. The IEP was not integrated in Individual #171's current ISP because his IEP was developed prior to his admission to school, however, the facility was currently working with the school district to provide appropriate educational services, and was actively monitoring his educational progress. Therefore, the Monitoring Team rated this indicator as meeting criterion.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	0/1						0/1		
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2	0/1						0/1		
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2	0/1						0/1		
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2	0/1						0/1		
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2	0/1						0/1		
Comments: None.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. None of the individuals reviewed had ISPs that included clinically relevant, achievable, and measurable goals/objectives to address their communication needs. c. through e. The Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	#90	#123	#13	#119	#161	#5	#59	#24	#1
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. As noted above, ISPs were generally lacking needed communication supports.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
			Individuals:								
#	Indicator	Overall Score	#92	#161	#5	#85	#82	#19	#114	#152	#129
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	47% 7/15	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	20% 3/15	1/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		#117	#93	#90	#46	#189	#127			

a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		0/1	0/1	0/1	0/1	0/1	0/1			
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	0/1	0/1	0/1	0/1	0/1			
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	33% 2/6									
Comments: None.											

Domain #5: Individuals in the Target Population who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and will transition to the most integrated setting(s) necessary to meet their appropriately identified needs, consistent with their informed choice.

Outcomes, indicators, and scores for this Domain will be included in the next Monitoring Team Report.

APPENDIX A – Interviews and Documents Reviewed

Interviews: Interviews were conducted of individuals, direct support professionals, nursing, medical, and therapy staff.

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since the last review, with date of admission;
- Individuals transitioned to the community since the last review;
- Community referral list, as of most current date available;
- List of individuals who have died since the last review, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a ISP Preparation meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT in the past six months;
    - Individuals discharged by the PNMT in the past six months;
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube in the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - In the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - In the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - In the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - In the past six months, individuals who have experienced a fracture;
    - In the past six months, individuals who have had a fecal impaction or bowel obstruction;
    - Individuals' oral hygiene ratings;
    - Individuals receiving direct OT, PT, and/or speech services and focus of intervention;
    - Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received;
    - Individuals with PBSPs and replacement behaviors related to communication;

    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - DFPS cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by external peer review
        - Were reviewed by internal peer review
        - Were under age 22
    - Individuals who receive psychiatry services and their medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
    a. PNMT
    b. OT/PT and Speech

c. Medical
d. Nursing
e. Pharmacy
f. Dental

- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual's IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments

- For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
CBC	Complete Blood Count
CDC	Centers for Disease Control
CDiff	Clostridium difficile
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DOJ	Department of Justice
DSHS	Department of State Health Services
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, Throat
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IM	Intramuscular
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IV	Intravenous
LVN	Licensed Vocational Nurse
LTBI	Latent tuberculosis infection
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
NOO	Nursing Operations Officer
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PDCT	Potentially Disrupted Community Transition
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation
QA	Quality Assurance

QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Program
SO	Service/Support Objective
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus